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REHABILITATION LITERATURE

National Society for
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REHABILITATION LITERATURE

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REHABILITATION LITERATURE

Article of the Month

The Rehabilitation of Psychiatric Patients

Gerald Kissin, M.A.
and
Donald M. Carmichael, M.D.

About the Authors . . .

Mr. Kissin, psychiatric employment specialist with the New York State Department of Mental Hygiene, has since 1956 been vocational consultant to the aftercare clinics of the New York State Department of Mental Hygiene. He also is a staff counselor and a lecturer (psychology department) at the School of General Studies, Brooklyn College. From 1949 to 1956, he worked in the rehabilitation of former inmates of New York's penal system. He is a member of the National Rehabilitation Association, the American Personnel and Guidance Association, the Division of Rehabilitation Counselors of the APGA and the National Vocational Guidance Association. Mr. Kissin received his M.A. in 1950 from New York University Graduate School of Education.

Dr. Carmichael, director since 1954 of aftercare clinics in New York City for the State Department of Mental Hygiene, received his medical degree at Queens University in 1926. After postgraduate work in psychiatry and psychoanalysis at the Columbia-Presbyterian Medical Center and the New York Psychoanalytic Institute, he served in various capacities in New York state mental hospitals from 1931 to 1934. Dr. Carmichael is certified in psychiatry by the American Board of Psychiatry and Neurology and by the American Psychiatric Association as a mental health administrator. He is a member of the American Group Psychotherapy Association (President 1954-56), New York Society of Clinical Psychiatry, New York Academy of Sciences, and the American Association for the Advancement of Science. A fellow of the American Psychiatric Association, he is on its committee on rehabilitation.

This original article was written especially for Rehabilitation Literature.

Introduction

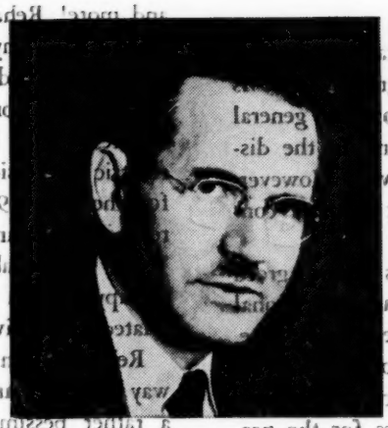
IN REHABILITATION, the mentally and emotionally ill constitute the disability group of most recent vintage. The idea of social and economic productivity in former patients arose only with a change in the basic philosophy regarding mental illness itself and with the change from custodial to therapeutic considerations.[1, 2] In this area are the most resisted concepts. From the concept that a person had to be taken care of—through the idea of one who had to be helped to take care of oneself—to that of a person who could take care of himself but might need some assistance in regard to particular difficulties has been slow and a by no means universally accepted change.

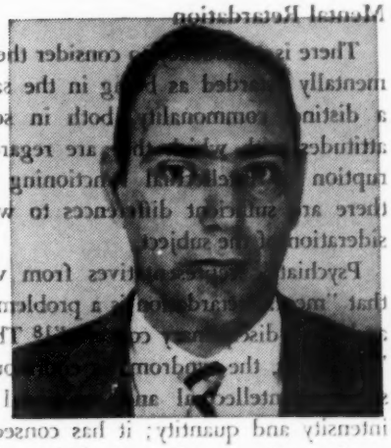
This paper will deal primarily with the rehabilitation of formerly hospitalized mental patients. This group is the only identifiable one; any other group of mental defective and/or mentally ill persons could be dealt with only on the basis of rankest speculation. How many neurotic, psychotic, and defective persons remain and continue to function in the community is not known, nor is there presently any way of finding out.

A 1953 review of the literature[3] concerning the rehabilitation of the mentally ill indicated a great paucity of material directly concerning this subject. In contrast, since that date practically every professional journal has published numerous pertinent articles and reports of investigations. Citation or recording of all material would be for us impossible. Therefore, this paper will attempt only to review the general trends and some of the projects and thinking in accord with these trends.

Perspective

Having established that we are going to discuss the hospitalized or posthospitalized mental patient, we are faced with the questions:





Left: Donald M. Carmichael

Right: Gerald Kissin

1) Quantitatively, is the problem of great enough magnitude to warrant the time and money involved in the necessary research and service? 2) Qualitatively, even if rehabilitation is possible, is the constitution of the group such that it would be more than an altruistic act and would result in a benefit to the community as a whole?

Neither of these questions is difficult to answer. Quantitatively, the problem is tremendous; familiar estimates state that from "1 in every 10" to "1 in every 4" persons will suffer from some sort of mental illness. A report of the National Mental Health Committee[8, 10] indicates that statistically "one out of every two hospital beds in the United States is occupied by a mental patient," and a 1945 report[9] (pre-World War II studies) showed that at any one time there were about 1 million persons who required hospitalization for mental illness, the annual admission rate being about 700,000. Figures have increased considerably since that time. Statistics indicated that approximately 2,500,000 people a year were treated for some form of mental illness.[10, 11]

Of all patients in tax-supported hospitals (1954),[10, 12] 71 percent were in mental hospitals and 89 percent of these were in state-supported hospitals. It would therefore appear that, in terms of magnitude and economic burden to the community, the rehabilitation of the mental patient is of greatest concern.

Qualitatively, the question revolves around the features of this group and their susceptibility to rehabilitation services. In 1959, an analysis of the population[13] (post-hospitalized) of the New York State Department of Mental Hygiene aftercare clinics* showed that 49.5 percent were between the ages of 25 and 45 years (described by the U.S. Bureau of Labor Statistics as the most productive years) and 82 percent were between 15 and 55 years of age. This New York sample of approximately 7,000 patients differs only in numbers from those of other states and areas. Furthermore, the increasing efficacy of psychotherapeutic tools has brought about shorter hospital stays and fewer rehospitalizations. However, this points up even more the need for all branches of rehabilitation to support and consolidate the therapeutic gains for this great group of persons in what should be the most productive period of their lives.

The history of the vocational rehabilitation of the mentally ill gives vivid examples of the slowness in development and of the resistances involved in the acceptance of this idea. Although there has been enabling legislation on the books since 1920, it was not until 1943[14] (Public Law 113, 78th Congress) that mental illness was recognized on the same basis as physical illness. This remained primarily a legal point until 1954, when with the passage of Public Law 565, 83rd Congress, vocational rehabilitation has been and continues to be extended to former mental patients to any appreciable extent. (This does not include the Veterans Administration, which in this area has, over the years, been far ahead of any and all state systems in regard to the vocational rehabilitation of the mentally ill.) Mary E. Switzer, director of the U.S. Office of Vocational Rehabilitation, recently pointed out that[15] ". . . the number rehabilitated among the mentally ill group in 1959 exceeds the *total* rehabilitated between 1943-1953." This becomes even more significant when she stated further that: "until 1957 the number of cases [rehabilitants] with a diagnosis of psychoneurosis exceeded by a considerable amount those with a diagnosis of psychosis." Therefore, the figures indicate that not only were the mentally ill a neglected group, but those who did receive service over the years were apparently for the most part the less seriously disabled. Furthermore, placement of the former mental patient, which has been recognized by the various state employment services as the "Number One Challenge"[16] at the present time, has proved both feasible and practical although still presenting problems. In the New York area the number of successful employment placements from this group far exceed their percentage of the disabled population.

*Figures include only patients on convalescent status from the state hospitals in New York City area and do not include those released from the state schools for mental defectives.

Mental Retardation

There is a tendency to consider the mentally ill and the mentally retarded as being in the same group. There is a distinct commonality, both in some of the general attitudes with which they are regarded and in the disruption of intellectual functioning involved. However, there are sufficient differences to warrant separate consideration of the subject.

Psychiatric representatives from various states agreed that "mental retardation is a problem of vast professional and multi-disciplinary concern."[18] They went on to state, "Clinically, the syndrome is enormously complex. It has somatic, intellectual and emotional aspects of varying intensity and quantity; it has consequences for the prenatal months as well as for old age; it presents elements of relative chronicity and more rarely of transience." In addition, the problem of "pseudoretardation" as opposed to "true retardation" has been a matter of controversy and discussion; we apparently have a long way to go before the complexities are understood.

Dr. P. W. Bowman[18] noted that "We have lagged far behind in utilizing modern psychiatric principles, new sociological insights and advanced educational and psychological methods to deal with the problems." However, a review of the literature and reports of the various projects and investigations relating to the etiology, treatment, and rehabilitation of the mentally defective would appear to question this conclusion.

Worthy of thought and consideration is the conclusion of the discussion group[18]—that "the community has never accepted its full share of responsibilities for the rehabilitation and utilization of mentally retarded individuals" and that the extension of educational, vocational centers to the mentally retarded might lessen the burden on the institutions that now carry more than their share.

The above is a superficial reference to the tremendous area in which a great deal is being done and a great deal more needs to be done. However, as indicated above, in spite of elements of inter-relationship, it is believed that there are sufficient differences between mental deficiency and mental illness and there is enough to be said about both to warrant separate discussion for each. The focus of this paper is in the area of mental illness.

Psychiatry

In the 1958 meeting of the Oklahoma State Health and Welfare Conference,[25] it was pointed out that "rehabilitation is not synonymous with preventive, physical, industrial or environmental medicine nor with public health, medical rehabilitation, social or comprehensive medicine, although it adds dimensions to all of these. It is not mere physical restoration, not just the 'third phase of medical care,' nor is it only 'returning to work.' It is all of these, and more! Rehabilitation is not the exclusive possession of anybody—any individual, profession or agency. However, all individuals, professions and agencies play their part in the community pattern and responsibility for services." This has been accepted by parts of the psychiatric profession; in a review of psychiatric progress for the year 1958[26] the changing status of psychiatric rehabilitation and treatment was discussed as follows: "Now it [rehabilitation] is becoming a part of total therapy, which is increasingly oriented toward interrelated preventive, therapeutic and restorative measures."

Rehabilitation of the mentally ill has come a long way from the anathema it seemed to represent. In 1952 a rather pessimistic outlook regarding progress in the field of mental illness was expressed in a statement, "There is a wide gap between the facts as we have them now and those we need to have. Indeed, to answer any one of the . . . questions requires a major research effort."[27] Currently, the changing attitude, increasing facilities, and acceptance of mental illness and mental patients have led to a more optimistic point of view. This view is reflected in a joint symposium of the American Psychiatric Association, the American Association for the Advancement of Science, and the American Sociological Society on the rehabilitation of the mentally ill, in the findings and attitudes reported by the Committee on Rehabilitation of the American Psychiatric Association, as well as in the reports of the Interdisciplinary Study Group.[28, 29, 37-40] The APA Committee on Rehabilitation has held a series of round tables of representatives of the various disciplines concerned with patients' rehabilitation, recognizing the worth of better communication and understanding by all concerned. The Committee recognized the importance of developing and utilizing to the full the as yet unrealized potential of all disciplines functioning in the care and treatment of the mentally ill. Recent developments in psychiatry have given this added emphasis. However, complete acceptance by the psychiatric profession is still to come.

While it is true that the general principles of treatment and the specific techniques are not new, rehabilitation differs from previous methods in the planned, as opposed to unorganized, attempts to mobilize all resources of the patient and the community.—Henry H. Kessler, M.D.

Temple Burling[30] in discussing this question at a 1948 meeting touched on a number of elements that apply even now. He noted: "It becomes all too easy for the psychiatrist dealing with psychotics to feel that the goal of treatment is the removal of psychotic symptoms, just as it is all too easy for the surgeon to feel that his respon-

sibility begins and ends with the removal of gallstones or an appendix. Removal of symptoms, however, is meaningless busy work unless it is one step toward the patient's return to full human living."

It is becoming increasingly accepted that, in dealing with the "emotionally disturbed" individual, the philosophy, methods, and goals of rehabilitation should prevail throughout, from the diagnostic through the discharge interviews. This is so because the goal of psychiatric treatment is the enablement of the individual to mobilize his assets through a reduction of the morbific factors, the reintegration of his personality, and the utilization of his assets in adequate community functioning. This is directly related to the avowed goals for the rehabilitation of *any* individual in *any* disability group.

The introduction and extensive use of drug therapy have brought about great changes in hospital management as well as in the treatment of the patient in the community.[31, 32] However, this must be viewed in perspective and can be summed up in the statement of Dr. J. T. Ferguson:[33] "A program of this type without facilities or personnel for rehabilitative measures is doomed to failure. . . . They [the drugs] only open the door to reality. How far the patient progresses to normalcy is the sum total of all efforts [including his own] in his behalf."

In addition to other developments, the changing concepts in psychiatry, the awareness of the lack of psychiatric personnel, and the increasingly widespread use of tranquilizing drugs in general practice are necessitating a closer working relationship between the psychiatrist and the general practitioner and also the extension of psychiatric knowledge and technics to the general practitioner.[34-36]

In general, advances in psychiatry have been marked by the development and increasing use of effective technics, more extensive cooperation with other disciplines and specialties, as well as the broadening of the concepts and goals for the patient as a member of society.

Veterans Administration

Of all the agencies, both public and private, the Veterans Administration facilities have had the longest experience and the best developed hospital rehabilitation programs. The passage of the Vocational Rehabilitation Act in 1918, providing for service to disabled veterans, made no differentiation between physically and mentally disabled. Since that date various laws providing benefits for veterans forced the provision and extension of services by the Veterans Administration. Since 1943, concomitant with the extension of rehabilitation in general, counselors were assigned to Veterans Administration hospitals, and hospital rehabilitation programs developed. Departments of rehabilitation within the hospital, with the assignment of counseling psychologists and other rehabilitation specialists, grew, as did concepts of industrial therapy and, finally, the member-employee program.[46, 47]

Review of available material seems to indicate a growth and development of inhospital programs, which at present are only beginning to be emulated by state facilities. However, there are a number of factors to be considered when comparing VA and state programs for the mentally ill. The differences between the two hospital systems, such as size and extent, as well as the characteristics of their population preclude a direct translation of the VA programs to state systems. However, the philosophy of early introduction of elements of rehabilitation into hospital treatment and of the gradual development of the individual patient in accord with a plan of rehabilitation is slowly being adopted by the states.

It is noted that, although far ahead of state hospital systems in hospital programing, the VA seems to lag behind the states in use of community agencies and services. This may well be due in part to the extent of the area that each VA hospital serves and the number of communities (and agencies) involved. Recognition of this lack of the federal facilities has been expressed and is being met by the extension of the hospital into the community in the form of aftercare clinics and day hospitals.[45]

Hospital

The hospital programs have, over the years, reflected the psychiatric thinking and the general attitude toward mental illness and the hospital's purpose current at that time. Temple Burling[48] referred to this aspect when he quoted the conclusions of the Committee on Psychiatric Social Work of the Group for the Advancement of Psychiatry. The Committee considered the mental hospital a treatment facility of the community "rather than a dump pile for the disposal of human wreckage." The increasing interest in and influence of European psychiatric methods,[49-55] with their emphasis on early treatment and short hospitalization, and also the continuing advances in treatment methods and resources (somatic and drug therapies) have helped change the concept of the function of the mental hospital toward this ideal. We have a long way to go from the stereotype of the mental hospital that carries with it "fear and terror, shame and stigma,"[56] which although markedly mitigated in light of the aforementioned developments still remains and exerts its influence upon the progress and acceptance of services for mental patients.[57]

The "open-door" policy, which has been both a result of the foregoing changes and a stimulant toward further acceptance of the mental patient as a member of society, has been the greatest single change in recent years. However, we are gradually becoming aware that the open

hospital itself is only another tool and that giving recognition to the status of patients as individuals, which this implies, also puts the pressure upon the hospital and the personnel thereof to provide meaningful programs.[58, 59, 61, 64] In accord with this changed status of the patient:

> The mental hospital, the much maligned citadel and repository for the negative attitudes toward mental illness, nevertheless is both necessary and desirable for many who can no longer be maintained in the community through available facilities. Positive factors in a hospital situation that are important in the patient's ultimate recovery and return to the community include his removal from the stress and demands of his current situation and the provision of the therapeutic milieu of a hospital and opportunities of gratification (through such activities as occupational therapy, recreational therapy, music therapy, and social opportunities) not available to him outside the hospital.[60] In this sense a hospital, in the terms used to describe drug therapy, is a means of opening the door to reality, enabling reintegration and rehabilitation to take place. However, hospitalization as presently constituted is a mixed blessing.[61] Institutionalization is an important cause of disability, and the public pressure for security forces upon the best of treatment-minded state hospitals a disabling custodial function. It is generally recognized that this cannot be lessened except by a change in public attitudes and concepts and responsibilities, which the open hospital is helping to foster. Furthermore, in the authors' opinion, institutionalization is not the result of too good a hospital adjustment but rather of a poor one, in that the patient has been unable to make use of his role as a patient and really avail himself of the advantages of hospitalization. The goal of hospital treatment is moving the individual to the point of being able to meet the community's demands and requirements.[62]
>
> Facilities directed toward the foregoing goals of hospitalization must be incorporated into the hospital program. All treatment and rehabilitation efforts should be part of a continuum beginning at a point prior to the patient's entry into the hospital and continuing through the period of hospitalization into his return to the community. These principles could well apply to persons known to community agencies who have never had a period of hospitalization.[63] Therefore, in discussing hospital programs we are talking about only one period in this continuum.

In accordance with this thinking, old established programs have changed and new ones have been introduced.[58, 59, 61, 64] Diversionary programs have now given way to programs aimed toward the patient's return to and reintegration into society.[65] Not only have the hospitals through aftercare clinics and day hospital programs moved out into the community, but the community, particularly in the area of vocational rehabilitation, has moved into the hospital.[62, 63]

It has been generally recognized that in all disability areas, including the psychiatric, vocational adjustment has been important in the former patient's return to community living. This, in fact, represents his move from full dependency status as a patient to the optimum economic independence of which he is capable. It has great meaning to those involved in his treatment as an observable indication of the success of the therapies and the level of adequacy of his functioning. It also has great meaning to the patient and his society, "wellness" and "illness" being held as synonymous with ability or failure to function as a contributing, working member of his community.[59, 66] The introduction of counselors from state divisions of vocational rehabilitation[64] and the inauguration of vocationally oriented occupational therapy, programs of industrial therapy, and sheltered workshops within the state hospitals are part of this pattern of recent developments.

The World Federation for Mental Health (19 Manchester St., London, W.1, England) has designated the year 1960 as World Mental Health Year (WMHY). Organizations in 43 countries make up the World Federation. Five projects designated for particular study during WMHY relate to the extension of knowledge and the development of technics pertaining to mental disease, its causes, prevention, and control. Dr. Kenneth Soddy, Scientific Director of the World Federation, serves as general supervisor of the projects. These and their results will be the focus of the International Congress on Mental Health, to assemble in Paris in September of 1961.

Although we in our public mental hospitals have for years been readily able to release our patients, more recently in increasing numbers, more return to the community is not enough. What is really essential is the restoration of the patient to a contributing role in society. We hear more and more from other countries about methods for the avoidance, as far as possible, of the necessity for the first or subsequent hospitalization through improved community mental health facilities. Contrasted with our European cousins, who appear to use hospitalizations as a last resort, and even then on a voluntary basis, our tendency has been, and still is, to advise an early hospitalization, mostly through judicial certification. The history of American psychiatry bears this out, showing as it does that for years almost all psychiatrists were identified with hospital psychiatry and until recently relatively few were in private practice or in community clinics.[67] As a result the public, lay and medical alike, have taken for

granted traditionally that government—federal, state, or municipal—will provide for our so-called indigent, mentally ill, *i.e.*, the vast majority of mental hospital patients, and that, therefore, we as individual members of society need be little concerned about the matter.

One of the dangers in the establishment of these various state hospital programs has been a tendency toward the establishment of pilot and token programs as well as piecemeal programs providing for no continuum.[68] The advent of the open hospital, the change in attitude regarding the status of the patient and ultimate purposes of hospitalization, and the growing tendency toward voluntary admissions all call for a more dynamic and community-centered system of programing for state hospitals.

Transitional Aspects of Rehabilitation

"It would indeed be fortunate if a mental patient could leave the hospital with the mental disease either cured or arrested, and also be completely rehabilitated, so that he could at once assume his optimal role without further help or specialized attention. Such is obviously not so, in fact."[69, 79, 80] It is in accord with the need established by this fact that the large number (although still not enough) of agencies and facilities have arisen. The provision of "vestibules" in the form of improved and enlarged aftercare services is the symbol of the meeting of therapeutic and community responsibilities and efforts.[70-75]

Since it is of importance to reduce the distance both literally and figuratively between the patient and society, it would be most desirable for mental hospitals to be located in the community they serve. However, considerations of security, which have heretofore been the major consideration in the provision and maintenance of mental hospitals, have precluded this. Therefore, the aftercare clinics have arisen as an extension of hospital and therapeutic care into the community. Physically located within easy access and a part of the larger pattern of services, the clinics are a buffer between the patient and (to him) the sometimes exorbitant demands of his situation. The psychiatric and social work help that are readily available at the clinic thereby provide support even beyond the actual services offered. Throughout the country there has been a marked growth of aftercare clinics and, in natural consequence, there has also been provided more intensive treatment facilities such as day hospitals. The day, night, and week-end hospital, as developed in Canada and some European countries, has met the needs for more intensive treatment without interfering with home and community functioning. In New York permanent aftercare clinics and the Brooklyn Day Hospital have set a pattern of cooperation with community facilities and agencies not practicable before their establishment.[76]

It is agreed that in our culture "Satisfying work provides self-respect, recognition, and prestige, a sense of usefulness to society. . . . And probably not the least of the values of work is the fact that it brings the individual into contact with other people on a stable, continuing basis, other workers in the same shop, office, or occupation providing a group with which he can identify as well as associate."[77] Therefore, a vocational adjustment is an important aspect of total community adjustment. Our experience has been that the same behavior that, when exhibited by a patient who was gainfully employed, was tolerated and accepted by those around him might well become a basis for rehospitalization if a patient loses his job or is unable to find one.[78] Not all patients need assistance in this regard but those who do need it badly.

The acceptance and recognition of a need gives birth to facilities to meet this need. Facilities have been extended and others organized to meet increasing needs brought about by the changing attitudes, treatment that the community is inadequate to meet, and status of patients. Programs such as social clubs for expatients have expanded, but the most evident changes have been in the increased establishment of halfway houses and the growth of the sheltered workshop movement in our country. All these have necessitated a reassessment of traditional roles and the inclusion in the team of a relatively new member, the vocational counselor.[81-83] However, a survey of rehabilitation centers and the status assigned "mental patients"[86] reveals that too few services are offered and that other factors must be recognized. One notes a distinct variation in availability of these centers to the former patient, a frequent attitude of wariness, and an opinion that special facilities and personnel would need to be added. In distinct contrast is the program of the Altro Health and Rehabilitation Service Workshop, extended first to mental patients from a private voluntary hospital and then to patients from the facilities of the New York State Department of Mental Hygiene. Experience at Altro has shown that the inclusion of such patients is both feasible and practical.[87-89]

In Vermont vocational rehabilitation coupled with a halfway house program has been proving itself likewise successful.[90] These are but two examples of projects being conducted throughout the country. However, for the most part, transitional services for former mental patients continue to be inadequate both quantitatively and qualitatively and replete with reservations and barriers to patients' utilization of such services.

Community Aspects

All efforts toward rehabilitation succeed or fail on the basis of the actions and attitudes of persons completely removed from any professional relationship with the patient. The family, the peer group, and the employer

hold the key to the patient's opportunity for adequate community functioning.[92-95] The goal of rehabilitation is to enable the individual to attain the level of functioning of which he is capable. Unless a situation within which he can attain this functioning is provided, all that went before is meaningless. No matter how good a plan has been evolved, nothing has been accomplished unless it can be implemented.[96]

It has been noted that "the recovered mental patient's principal handicap, in many cases, is the handicap of public opinion, a stigma which can follow him . . . and create an obstacle toward his making a full return to normal living."[97] Even further, "The sole fact that he was a mental patient often outweighs, in the public mind, any positive qualities he has as a human being." This is reflected in the attitudes of the sheltered workshops[98] as reported in the previous section and underlies some of the statements in official publications relating to the rehabilitation of the mental patient.[99] It is usually expressed indirectly in such phrases as "Need special conditions and/or personnel;" "Need careful screening;" "Long-term and complex." Gordon Allport, the social psychologist, once said, "It is easier to smash an atom than a prejudice." We all know what has happened to the atom, but our progress has been decidedly retarded in regard to this prejudice.

The question of attitudes, both lay and professional, as a key factor in the successful reintegration of a former mental patient into society is being recognized. The research project being conducted by the World Federation for Mental Health* is only one of a number of research projects in this area.

Community acceptance can be considered in two parts. First, unless those who are professionally involved in the patient's rehabilitation have faith in the patient's ability to function, they cannot expect such belief from the general public. Too often we damn with faint praise. A half-hearted attempt is worse than none. It is truly fortunate that in some instances public opinion has gone beyond that of professionals.[100] Secondly, the attitude of the general community, the world to which the patient returns, must be susceptible to his successful reintegration. Richard Williams referred to the importance of this aspect when he noted that an initial step would be ". . . precisely to determine the dimensions of the community to which the patient returns."[101] The principal dimension of this community is the attitude toward the patient.

Nothing can supplant an individual's own motivation and ability to utilize his capabilities. However, the community cannot abdicate its responsibility. At a meeting concerned wth the rehabilitation of the handicapped, this was expressed rather clearly. It was said, "We do not ask that the disabled be given greater opportunities for development than his fellowman, but we do grant him the right to expect that, where knowledge is available to minimize his disability and to equalize his opportunity, he should receive the benefit of this knowledge."[102] Therefore, it follows that it is our responsibility to help establish community services and opportunities commensurate with the needs and abilities of the individual.

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Follow-up of Graduates from a Cerebral Palsy Preschool Rehabilitation Program

Raymond H. Holden, M.A.

THE EVALUATION of programs for the cerebral palsied is an important need in research. One way of evaluating the effectiveness of treatment in a program is to determine the disposition of children graduating from the treatment training program. This brief report presents some evidence of what happens to nursery school graduates from one children's rehabilitation center, the Meeting Street School in Providence, R.I.

Mr. Holden is clinical psychologist with the Meeting Street School Children's Rehabilitation Center, 333 Grotto Ave., Providence 6, R.I., and for the Institute for Research in Health Sciences of Brown University.

The philosophy of this rehabilitation center is based on two concepts, (1) early diagnosis and (2) integration of the therapies (physical, occupational, and speech) into the nursery school program. The therapists translate growth and rehabilitation principles into play needs of young children.

The table gives the school disposition of 64 children who were followed after leaving Meeting Street School, where they had all been attending nursery school groups. The number graduated varies from year to year, from 1956 through 1959, but the over-all percentages give an interesting picture over a four-year period. Fifty per cent of the children were placed in regular class settings in the public school systems in Rhode Island; 30 percent of the children needed special placement, either in an ungraded class or a trainable or educable class. Only six children were institutionalized; of these, two needed long-term inpatient treatment for orthopedic problems, three needed the security of a school for the deaf because of severe hearing loss, and one needed the protective environment of a children's hospital for emotional disorders. Seven children were so severely handicapped, physically or

Disposition of Graduates from Meeting Street School, July, 1956, Through July, 1959

	1956	1957	1958	1959	Total	Total in %
Regular Class	1	11	3	17	32	50
Special Class	3	8	3	5	19	30
Institutional (Kennedy, Deaf, Bradley)	0	3	2	1	6	10
Home Teacher	1	2	4	0	7	10
	5	24	12	23	64	100

THIS MUCH AWAITED book . . .

intellectually, that they required a home teacher, since they could not attend special classes, even on a limited basis.

It is felt that, from the point of view of treatment programs, results are encouraging. 50 percent of the children can be graduated to a regular school placement without further need for intensive physical treatment programs. These results certainly emphasize strongly the need for early diagnosis and treatment of all cerebral palsied children, so that rehabilitation can proceed even before formal education begins.

Reprints of Article of Month for April Now Available

Dr. Christopherson's article, "Role Modifications of the Handicapped Homemaker," featured in the April issue, has been reprinted and is available as Reprint DR-25 at 25¢ a copy. Orders for less than $1.00 should be accompanied by payment. Inquire for special prices for quantity orders.

In the June Issue

The Article of the Month for June is "Professional Education, a Rehabilitation Center Responsibility," by Isabel P. Robinault, Ph.D., Director of Professional Education, Institute for Crippled and Disabled, New York. The Review of the Month will be of *Speech and Brain-Mechanisms*, by Wilder Penfield and Lamar Roberts, which has been reviewed by Hildred Schuell, Ph.D., Director of the Aphasia Clinic, Veterans Administration Hospital, Minneapolis.

Review of the Month

Chronic Illness in the United States, Vol. III

Chronic Illness in a Rural Area: The Hunterdon Study

Reported by

Ray E. Trussell, M.D., M.P.H.
and
Jack Elinson, Ph.D.

Published for The Commonwealth Fund by Harvard University Press, 79 Garden St., Cambridge 38, Mass. 1959. 440 p. tabs., forms. $7.50.

Reviewed by Edward S. Rogers, M.D.

THIS MUCH AWAITED book completes the series of four volumes of the general report authorized by the Commission on Chronic Illness at the end of its seven-year existence in 1956.* In order to appreciate the particular place of *The Hunterdon Study* in the total scope of the Commission's work, we may draw from the statement on the "History of the Commission" appearing in Volume I. The program of the Commission fell broadly into three areas: gathering information about the nature and extent of chronic illness, formulating general conclusions and recommendations from these findings, and disseminating information with the intent of encouraging and aiding programs and studies in the chronic disease field. It early became evident to the Commission that extensive research would be necessary to obtain the requisite information about the nature and extent of chronic illness. However, as a matter of policy the Commission preferred to stimulate research by others, and only in a few instances did it find it essential to undertake major studies itself. *Chronic Illness in a Large City: The Baltimore Study* (Vol. IV of this series) constitutes the largest of its few undertakings in this respect. To be sure, the Hunterdon County study, with which this review is chiefly concerned, was Commission-sponsored, but, in the main, it arose from the timely interest of its senior author, Dr. Ray Trussell, who brought it more or less ready-made to the Commission with the suggestion that it would be the ideal rural counterpart to the urban study being planned in Baltimore.

About the Authors . . .

Dr. Trussell is chairman and Dr. Elinson associate professor, School of Public Health and Administrative Medicine, Columbia University. Dr. Trussell was director of the Hunterdon Medical Center, Flemington, N.J., from 1950 to 1955. He received his M.D. degree from the University of Iowa in 1928 and his M.P.H. degree from Johns Hopkins in 1947.

Dr. Elinson was formerly senior study director of the National Opinion Research Center, Chicago, Ill. He received his M.A. degree in 1946 and his Ph.D. degree in social psychology in 1954, from George Washington University.

About the Reviewer . . .

Dr. Rogers has been professor of public health and medical administration, School of Public Health, University of California, Berkeley, since 1946. Dr. Rogers, a founding member of the Commission of Chronic Illness, has long been active in public health work. He currently is chairman of the Public Health Research Study Section, National Institutes of Health, and a member of the Expert Advisory Panel on Health Statistics of the World Health Organization.

*All published by the Harvard University Press for The Commonwealth Fund, the other volumes comprising the report of the Commission on Chronic Illness in the United States are: Vol. I, *Prevention of Chronic Illness*, 1957; Vol. II, *Care of the Long-Term Patient*, 1956; and Vol. IV, *Chronic Illness in a Large City: The Baltimore Study*, 1957.

As a balanced pair, one urban and the other rural, it was most important that these two studies use definitions and methods that would make direct comparisions of their findings feasible. The inability to make such comparisons between and among various studies conducted in different places and at different times has been one of the great deficiencies in this area of research. Although the planning for both of these studies was carried out in the closest cooperation and followed the lines suggested by the Commission, the Hunterdon Study was financed largely through the direct support of the Commonwealth Fund as a part of its wider interest in the Hunterdon Medical Center and its community role. Actually, the Hunterdon study got under way first and the Baltimore study, which followed it closely, was in a position to profit a great deal from the prior experience in Hunterdon County with the new methods that both studies contemplated and employed. In reporting the methods and findings, therefore, Vol. IV (the Baltimore study) has the occasion to be somewhat of a summary of both studies and, in itself, to reflect the greater methodologic sophistication made possible by its later position. Conversely, Vol. III (the Hunterdon study) has the characteristic freshness of a pioneer attempt, yet, being actually the last written of the two reports, it also has the opportunity for retrospective insight in critical analysis of its findings, made possible by knowledge of what was done in Baltimore. This opportunity is effectively used by the authors.

In content both these studies are of great value to persons concerned with planning for the prevention, control, and care of chronic illness. They cast an entirely new light on both the nature and prevalence of chronic illness and on the difficulties inherent in surveys intended to determine the morbidity status of a community. They give important clues to a better understanding of the exact nature of the problems posed by chronic illness in terms of existing and potential disability; in terms of attitudes toward illness and medical care; in terms of opportunities for effective primary or secondary prevention and rehabilitation; and in terms of the types and numbers of institutions and other facilities that probably would be required to furnish all the care that medical science has the knowledge and skill to offer today. Finally, these studies are of the utmost importance in their technical contributions to the process of morbidity surveys. In fact, they already have greatly affected the patterns of several other important studies, including the current National Health Survey.

The major findings of the Hunterdon study have been summarized in the beginning of the book under the heading *Highlights of the Survey.* These 29 pages are important reading for everyone who is at all deeply concerned with community health. The findings are better comprehended in the setting of the report itself than with any attempt that might be made here to separate them out of a context that is so much a part of them. For example, the study shows clearly the many inadequacies of the household interview method in morbidity surveys as a means of determining the prevalence of chronic illness, even illness of comparatively severe nature. Yet, it also reveals in considerable detail just what may be expected of the household interview survey and thereby adds substantially to the actual usefulness of this tool in morbidity studies.

In terms of the methodology of morbidity surveys, the Hunterdon study pioneered in matching the findings of household interviews both with those of "multiple-screening" batteries of laboratory tests and with findings of complete diagnostic physical examinations. These comparisons showed that there is yet much work to be done before we shall have a practical, inexpensive method of determining disease prevalence. Neither the household survey nor the multiple-screening methods proved very reliable, though for different reasons. The former encountered difficulties chiefly because of ignorance, misunderstanding, and reticences on the part of the respondent in the interview, while the latter presented a major problem in getting a representative sample of the community to submit to the laboratory tests offered.

Despite their limitations, the specific findings of the Hunterdon and the Baltimore studies are so carefully analyzed and the study methods so thorough that they provide us for the first time with disease-specific morbidity data in which considerable confidence may be placed. While these data may not be generalizable in detail to other geographic areas and, in fact, differ significantly between the two areas studied, they probably can be translated in broad terms to the country as a whole. More importantly and, as pointed out by the authors, these "data are so markedly at variance with heretofore prevalent notions about chronic disease, disability, and needs for care that new thinking about these subjects must be induced."

In addition to prevalence data and methodologic considerations, the Hunterdon study presents findings, the implications of which cannot escape those interested in the organization and provision of medical care. These findings are summarized by Levin and Mayo in their preface to this volume. In selecting what they consider to be the most significant findings of the study these authorities have chosen the following: the appraisal of a level of over one-third preventability among the chronic conditions found by the medical evaluation teams; the evidence of serious inadequacies in the medical care that had been received by as many as 60 percent of persons with currently or potentially disabling illness; and the wide margin of difference between the number of persons in need of medical care and those who actually received it.

By this notable work and its companion study in Baltimore, our knowledge about chronic illness has been greatly advanced and technical competencies have been developed that will continue to contribute to research and programs in this important area.

Other Books Reviewed

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Functional Anatomy of the Limbs and Back; A Text for Students of Physical Therapy and Others Interested in the Locomotor Apparatus

By: W. Henry Hollinshead, Ph.D.

1960. 403 p. illus. tabs. (2d ed.) W. B. Saunders Co., W. Washington Square, Philadelphia 5, Pa. $9.00.

ORIGINALLY ISSUED in 1951, this revision of a well-known textbook retains the five major divisions used in the first edition. General information is presented in the first and last sections, with more detailed descriptive discussions of the limbs and back in the three sections intervening. Extensive revisions in both the text and the illustrative figures are noted; numerous cross references have been added throughout the text as an aid to better understanding by the student. Intended for the beginning student of anatomy, with particular thought for the needs of those studying physical therapy, the book could also serve as a ready reference source for the medical graduate.

311

Government and the Handicapped; The Alabama Vocational Rehabilitation Program

By: George R. Weir

1960. 77 p. tabs. Paperbound. Bureau of Public Administration, University of Alabama, University, Ala.

THIS ANALYSIS of the Alabama Division of Vocational Rehabilitation and Crippled Children; its history, organization, and management and its current programs and services examines federal and state agency cooperation and the specific problems of administering vocational rehabilitation services through a single agency. In the author's opinion, such an administrative setup is a definite asset, contributing to the economy of administration and promoting closer cooperation among all personnel involved in the various phases of the program. Recommendations are offered for improving the vocational rehabilitation program in Alabama.

312

Guidance Programs for Blind Children; A Report of a Conference, April, 1959, Perkins School for the Blind, Watertown, Massachusetts

Edited by: Carl J. Davis

1959. 142 p. (Perkins publ. no. 20) Perkins School for the Blind, Watertown 72, Mass. $2.00.

PURPOSE OF THE Conference was the establishment of a practical and theoretical framework for the organization or improvement of guidance programs in both residential and day schools for the blind. Participants were administrators, guidance specialists, and teachers preparing to enter guidance work.

Contents: Introduction to guidance programs with blind children, C. J. Davis.—The purpose of a general guidance program, David V. Tiedman.—A comparison of self-concepts of blind and sighted children, Frederick M. Jervis.—Diagnostic procedures for use with blind children, Eunice L. Kenyon.—Application of guidance principles in a school for the blind, Carl J. Davis.—The role of the school in child-home relationships, Rachel Rawls.—Group procedures with staff and with parents, William Valdina.—The public school counselor works with a blind pupil, Theodore Clapp.—Panel discussion: How guidance procedures may be established in a residential school, John E. Chiles, William H. English, and Lee A. Iverson.

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The Health of People Who Work

Edited by: Albert Q. Maisel

1960. 268 p. National Health Council, 1790 Broadway, New York 19, N.Y. $4.50.

PRACTICAL SUGGESTIONS to aid those responsible for business management in maintaining the well-being and productivity of the working force are contained in this edited report of the 1959 National Health Forum. More than 200 industrial medical directors, physicians, nurses, management officials, public health officers, voluntary health officials, and other experts in the field of occupational health met to discuss ways of developing more effective industrial health programs. The special problems of establishing and administering a program in the small business or plant were considered, since there is a definite lag in preventive health services in this segment of industry. Mental health, placement of workers (including selective placement of handicapped workers), workmen's compensation, problems of retirement, occupational safety, and administrative problems of the staffing of the medical department are but a few of the topics discussed at the Forum. Member organizations of the National Health Council are listed with their addresses. The general index should be useful in locating topics of special interest.

314

A Manual for Occupational Therapists on Prevocational Exploration

By: Jack Granofsky, Ph.D.

1959. 43 p. Spiral binding. Paperbound. Wm. C. Brown Book Co., 135 S. Locust St., Dubuque, Iowa. $1.75.

LITERATURE ON prevocational exploration (or evaluation) is beginning to appear in more abundance; this particular contribution should be welcome, since it defines the nature of the prevocational process and the specific role of occupational therapists in this area of vocational rehabilitation. Basic procedures upon which a comprehensive prevocational program should be organized and administered are discussed step by step, sample forms useful in the recording of data on patient characteristics are included. Dr. Granofsky, Special Lecturer in Occupational Therapy at the College of Physicians and Surgeons, Columbia University, has used the manual in actual classroom situations to acquaint students with the potentials and responsibilities of the therapist in prevocational exploration.

315

Music Therapy, 1958; Eighth Book of Proceedings of the National Association for Music Therapy; Papers from the Ninth Annual Conference, Cincinnati

Edited by: Erwin H. Schneider and Ruth Boxberger

1959. 331 p. The Allen Press, Lawrence, Kan. $5.20, postpaid.

AMONG THE PAPERS presented at the 1958 Annual Conference of the Association, those in Parts IV, V, VI, and X, concerned with music therapy as a tool in special education, in physical medicine, and in the therapeutic treatment of exceptional children, will be of special interest to those in the rehabilitation field. Current research relating mainly to the psychological aspects of music therapy is reported in a series of eight papers in Part X. The extensive bibliography of selected references compiled by Helen Ann Dinklage (p. 249-293) is of special value due to the many unpublished theses cited. (For previous annotation of the article "Music as a tool of physical medicine," by Barbara Dehnholz, see *Rehab. Lit.*, April, 1960, #270.)

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Ring the Night Bell; The Autobiography of a Surgeon

By: Paul B. Magnuson; edited by Finley Peter Dunne, Jr.

1960. 376 p. Little, Brown and Co., 34 Beacon St., Boston 6, Mass. $5.00.

SOME MAY KNOW Dr. Magnuson for his outstanding clinical work in bone and joint surgery. Others may recall his fight, alongside General Omar Bradley and Dr. Paul Hawley, on behalf of disabled veterans during the reorganization of the Veterans Administration after World War II. He will be remembered more recently for his work as chairman of President Truman's Commission on the Health Needs of the Nation. Credit is due him for his early interest in rehabilitation, evident when he first treated injured stockyard and railroad workers in the little office over a saloon, later while he served as examining physician for the workmen's compensation cases of the Illinois Industrial Commission, and still later during his richly remunerative practice as a Michigan Avenue surgeon. The founding of the Rehabilitation Institute of Chicago, for which he was the prime mover, climaxed his career.

The highly successful and controversial career that Dr. Magnuson has had is well conveyed in his autobiography. One finds in it the forthrightness, independence, and zest for action that characterized his dealings with his patients and fellow physicians and with government officials. Dr. Magnuson observes that there is very little gray in the opinion people have of their doctor or their minister. From the book, one finds very little gray in Dr. Magnuson's opinion of other people.

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Social Casework and Blindness

By: Samuel Finestone, Martin Whiteman, Fern Lowry, and Irving Lukoff; edited by Samuel Finestone

1960. 157 p. Paperbound. American Foundation for the Blind, 15 W. 16th St., New York 11, N.Y.

CASEWORK WITH the blind is emerging as another specialized field of social work practice and calls for specialized knowledge of the sociocultural, physical, psychological, and emotional impact of blindness upon the individual. The scope of this monograph has been limited to discussions relating to casework practice with adult blind clients; it is intended as a teaching tool for workers whose responsibility is to aid, on an individualized basis, blind clients seeking solutions to social and personal problems.

Contents: Introduction, Fern Lowry.—Basic assumptions underlying casework with blind persons, Fern Lowry. —A sociological appraisal of blindness, Irving Lukoff.—A psychological appraisal of Blindness, Martin Whiteman. —The implications of blindness for the social caseworker in practice; implications for the study process.—Implications in the diagnostic process.—Implications in the treatment process, Fern Lowry.—The family in the rehabilitation of blind persons.—Caseworker and community.—Selected bibliography.—Appendix: Blindness; some facts and figures.

Digests of the Month

Journal articles, chapters of books, research reports, and other current publications have been selected for digest in this section because of their significance and possible interest to readers in the various professional disciplines. Authors' and publishers' addresses are given when available for the convenience of the reader should he desire to obtain the complete article or publication. The editor will be most receptive to suggestions as to new publications warranting this special attention in Digest of the Month.

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Report of the Council on Rehabilitation, Medical Society of the District of Columbia: Part One, Rehabilitation; Part Two, Physician Survey

By: **The Council on Rehabilitation, Medical Society of the District of Columbia, and The Metropolitan Medical Societies of Maryland and Virginia**

1960. 226 p. tabs. Mimeo. Paperbound. Medical Society of the District of Columbia, 1718 M St., N.W., Washington 6, D.C. $1.50.

A BROAD three and a half year study of rehabilitation programs and facilities in the Washington Area (extending into the Virginia counties of Alexandria, Arlington, and Fairfax and the Maryland counties of Montgomery and Prince Georges) was conducted by the Council on Rehabilitation with the support of a grant from the Office of Vocational Rehabilitation.

The pattern of services to the disabled found in the area lacks structure and unity of organization, but the picture is by no means entirely negative. It was gratifying to find that community concern and involvement are widespread and that the concept of rehabilitation is extensively embodied in the thinking and planning of community agencies and services. In care and treatment, certain aspects have exceptional resources and facilities while others are underdeveloped or segmented. All phases or components of total rehabilitation were found to exist to some degree.

The experience gained and observations made over three years while collecting data on the programs and facilities existing led to the conclusion that the most productive approach to rehabilitation planning at the metropolitan level is through small, specialized study groups. Each would deal on a continuing basis with a clearly defined problem area.

The following were reviewed as problem areas such study groups would approach: 1) establishment of a central information service, 2) extension and strengthening of community resources in the diagnosis and early treatment of mental illness, 3) development of standards in recording and reporting of statistics and development of procedures for follow-up of clients served, 4) improvement, coordination, and expansion of resources for evaluation and screening of clients, 5) evaluation of the role of the general hospital and its potential in the future pattern of rehabilitation services, 6) evaluation and definition of the role of home-care programs in the provision of treatment and rehabilitation, 7) extension and strengthening of special education services in the public schools, 8) a more clearly defined approach to problems of placing the handicapped, 9) exploration of solutions to the problem of dependable transportation for the disabled, 10) planning and extension of social activity and recreation programs for the disabled and the aged, 11) implementation of the observations and conclusions of the committee on sheltered workshops.

A problem area should not be viewed entirely separately —setting limits should be a means of focusing on the area. Such study groups should be under a permanent metropolitan rehabilitation planning body. A study of the part the "neighborhood" can play in identifying and solving needs and problems of the disabled was suggested.

As a supplement to the broader three-year study of rehabilitation resources and facilities in the Metropolitan Area, a survey was made of the physician's needs, use of agencies, and his evaluation of services and resources. Questionnaires, sent to 2,106, were returned by 589 physicians, and 578 forms were used for the study. It was felt that an invaluable indicator of the adequacy and effectiveness of present programs and facilities would be provided by the experience of the physician in securing services for his patients and by his attitude toward the community's organized services. It was believed the physician's opinion of the need for additional rehabilitation services, in regard both to programs and facilities and to specific disabilities, might furnish a guide to sounder development of rehabilitation services in the Area.

The greatest priority of need was given by physicians to resources: 1) that would better meet mental health problems, 2) for medical and psychiatric treatment and rehabilitation of the alcoholic, 3) for the care and rehabilitation of the chronically ill, and 4) for care and rehabilitation in treating disabling conditions associated

with aging. The physicians stressed the importance of some form of central information and referral service.

Of the 578 physicians participating in the study, 481 (83%) reported that in the three months preceding the survey patients of theirs had needed services other than they gave. An additional 45 completed this section of the questionnaire but found no need for additional services. Major needs reported are as follows (percentages are based on total of 526 responding on section):

Psychiatric diagnosis or treatment	61.2%
Physical therapy	52.9%
Home nursing	44.9%
Psychological testing or counseling	33.5%
Institutional care (other than short-term hospitalization)	30.2%

Physicians were most successful in obtaining home nursing and physical therapy when needed and least successful with special placement and homemaker service, even though the latter two were less frequently checked "needed."

Eighty-one percent, 468, of the 578 physicians surveyed reported they had referred patients to at least one agency in the preceding three months. Of the 545 physicians completing this section of the questionnaire, 52.1 percent referred patients to the Visiting Nurse Associations, 39.1 percent to hospital departments of physical medicine, 35.6 percent to public health clinics (other than mental health clinics), 29.5 percent to adult mental health clinics, 26.2 percent to public welfare departments, and 24.8 percent to mental health clinics or other facilities for the emotionally disturbed child. Referrals to other types of agencies were made by smaller percentages of the doctors.

Ninety-eight percent, 566, of participating physicians evaluated the need to expand one or more of the types of service or facility in general use in care and rehabilitation. Of this number, the following percentages favored expansion of the types of facilities listed:

Institutions for the chronically ill, or long-term patient	70.0%
Information-planning center for rehabilitation services	67.3%
Provision in the general hospital for observation and short-term care of the psychiatric patient	66.6%
Mental health clinics	63.8%
Nursing and convalescent homes	60.1%
Clinic and hospital rehabilitation facilities for the alcoholic patient	55.5%
Social and recreational opportunities for the aged	47.5%

Eight-four percent, 484, of the physicians participating checked one or more disabling condition as needing additional services or facilities. Findings of this survey closely paralleled those of a San Francisco study:*

Rank	*Washington*	*San Francisco*
1	Mental Illness	Alcoholism
2	Alcoholism	Mental Illness
3	Hemiplegia	Paralytic Conditions (other than paraplegia and poliomyelitis)
4	Arthritis and Rheumatism	Arthritis and Rheumatism
5	Mental Retardation	Cancer
6	Cancer	Mental Retardation
7	Cardiovascular Disease	Heart Disease

Thirty-five percent, 201, of the total physicians wrote that aspects of agency service or functioning could be improved as to service to the patient and to the physician. It was frequently commented that information on available services and means to secure them should be easily accessible to physician and patient. The solution most frequently suggested was the establishment of a central information, or central information and referral, center. Pointed out was a need in many agencies to simplify referral and intake procedures, to initiate service to the patient promptly with a minimum of "red-tape," and to keep the patient's personal physician currently and fully informed as to action taken and progress made. Another need expressed was better interagency communication and coordination in community planning and provision of services.

Observations

The proportion of physicians indicating they were successful in obtaining needed psychiatric diagnosis or treatment (79.2%) was at variance with the priority assigned by Area physicians to the development of more adequate mental health resources (86.4% of 484 physicians checking section). This may be because: *a*) physicians tend to underestimate the need or to overestimate their success in obtaining such service, *b*) some token service was obtained but it was nominal and inadequate to the needs of the patient, *c*) physicians were successful in obtaining psychiatric service for patients who were able or somehow managed to pay for private psychiatric diagnosis or treatment, but the needs of the low- or middle-income patient were not met.

Physicians gave a high priority (39.7%) to additional services or facilities for treating and rehabilitating hemiplegic patients; this seems to conflict with the success the physicians had indicated in obtaining physical therapy and with their evaluation of the need to expand such services. This suggests that resources, while fairly adequate

**San Francisco Doctors Report on Community Needs and Resources in Health and Rehabilitation*, Community Health Services Committee, Health Council, United Community Fund of San Francisco. September, 1957.

for other than the hemiplegic, cannot handle needs of the stroke patient under a private physician's care.

Geographic variations in response suggest that local availability of a certain service may influence the perception of need of it. If a service is lacking or not known, a physician may be less apt to think of it as needed for his patients. This was reflected in comments on the need for homemaking service, for example, then available in only one area.

In general the physician tended to see a need for, to use, and be able to evaluate the services available to him in a medically based setting. The less a rehabilitative service was closely connected with or conducted in hospitals and clinics, the less likely was a physician to be familiar with it and use it. Some agencies evidently have failed in establishing this close liaison.

Of interest is the fact that the Visiting Nurses Associations were regarded with general satisfaction. This approval seems to stem from these reasons: All economic levels are served; fees are adjusted to the patient's ability to pay and indigent patients are served with no fee. Immediate service is given, with information secured later. The personal physician receives a continuing report on service and problems arising. All the staff work under the physician's guidance.

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Rehabilitation of Chronically Ill Psychiatric Patients By: William D. Wheat, M.D., Regina Slaughter, MSSW, and Jerome D. Frank, M.D. 1960. (33) p. Mimeo. tabs., forms. Issued by the authors, Johns Hopkins Hospital, Henry Phipps Psychiatric Clinic 251, Baltimore 5, Md.

A PILOT STUDY on the vocational rehabilitation of chronically ill psychiatric outpatients was conducted from September, 1957, to March, 1959, by Johns Hopkins University School of Medicine and the Maryland Division of Vocational Rehabilitation Service (VRS), supported by a grant from the Office of Vocational Rehabilitation. Objectives were to obtain better understanding of the rehabilitation process and better knowledge of criteria for selection of patients for treatment programs and to find out if a psychiatric service facility associated with VRS would be justified.

Generally, privately practicing psychiatrists or outpatient clinics had been receiving the VRS referrals of psychiatrically disabled clients. Handling these referrals was a small part of the total work; hence, the psychiatrist, in particular, had little opportunity to grow familiar with problems in rehabilitation. In communications to counselors he tended to use psychiatric terms offering no concrete guidance.

In our study, evaluation and treatment were given for 18 months, each patient first being evaluated by the project psychiatrist and social worker. For six months assignment to treatment programs was random. Later it was specific. Progress and planning were discussed regularly at staff conferences with vocational counselors. Of the total of 30 patients in our data (9 male, 21 female), 21 were assigned to group therapy and 9 to social work counseling. Of group therapy patients, 11 were followed for a year and 10 for 6 months or more. In social work counseling, five were followed for a year and four for over six months. Seventy-five percent of the patients were under 40 years of age and of lower-class status. Intelligence was average, but 45 percent had less than a ninth grade education. Early onset and chronicity of illness appeared to limit significantly educational achievement. Fifty-four percent had been hospitalized.

In 16 the diagnosis was character disorders, in 9 schizophrenic reactions, and in 5 neurotic reactions. Almost all those with a personality or character disorder were products of and existed in a lower-class socioeconomic milieu. Most had strikingly apparent traits that are pathological by middle-class standards but appear compatible with or slight exaggerations of values and attitudes of lower-class culture. Examples of this are lack of social responsibility and initiative, "let the other fellow do it" attitudes, low expectations of their own achievements, and a high expectation of others as to material and emotional sustenance. Patients of this type usually develop in an atmosphere where defeat, feeling overpowered or trapped, apparently is the norm. Defense is managed with rigid rules of conduct and rigid attitudes, through which blame is projected onto "controlling forces" and is expressed by low or absent social responsibility, lack of venturesomeness, low initiative, and lack of ambition—frustrating to the middle-class counselors, social workers, and psychiatrists. Middle and upper-class values are reflected in our classification of psychopathology. Commonly used treatment technics are most successful with rather than the lower class. Not representative of the psychiatrically disabled in the community who could benefit from the services, these clients present the most challenging and difficult rehabilitation problems. The less chronic patient is less apt to be referred, perhaps because the treating agent (private psychiatrist) is not familiar with the agency. Largely referrals come after the patient has become a chronic community and family problem. The complexity and chronicity of these patients make functional evaluation, treatment, and vocational planning lengthy processes.

All our patients lived in a family setting, often grossly unstable. By our ratings, about half lived in moderately or markedly disorganized families. In 87 percent, support came totally or partially from the family or public funds. Only 53 percent had held a job longer than a year; job tenure was not related to age, education,

or diagnosis. On scales measuring self-concept and social adjustment, scores were consistently below average, with the relatives' rating of the patient's social adjustment even lower than his own in 80 percent. With the Tennessee Department of Mental Health Self-Concept Scale, the mean initial score for the 15 who became vocationally successful during the study was 31.3 as compared to 54.9 for the unsuccessful. Twice as many unsuccessful as successful scored above the median for the total group. One might deduce that a chronically disabled psychiatric patient with a fairly positive self-concept is less apt to be successfully rehabilitated than one with a self-concept more in keeping with his history. The fairly positive may be unrealistic about himself and may reveal a degree of self-satisfaction or self-acceptance indicative of low motivation for change. The self-concept scale did not prove useful as an index of *change* in patients that might be associated with vocational success or its lack—there were no differential patterns of change of self-concept between the unsuccessful and the successful.

Group Therapy.—The 54 weekly group therapy sessions each lasted an hour and a half. Ten of the total of 21 patients completed the project, with an average attendance of 80 percent. The 11 drop-outs averaged 40 percent attendance. Over-all attendance averaged 61 percent. After 30 meetings with a free-interaction therapeutic technic, the last 24 were more structured with active informal participation by the therapist and by the social worker, formerly a nonparticipating observer. Both action and discussion were emphasized. After 12 structured meetings, the group, numbering 15 at the time, split into a day group of 9 and a night group of 6 who were in training or had secured work. The latter quickly became a free-interaction discussion group with the tacit permission of the therapists.

Of 18 patients active in group therapy when the project closed, 7 were to continue individual or group treatment in outpatient facilities, 7 were discharged as able to function adequately without formal treatment, and 4 refused further needed treatment or facilities could not be immediately arranged.

Individual Counseling.—Three of the nine patients having weekly individual interviews with the social worker were enrolled in the Henry Phipps Psychiatric Clinic outpatient occupational therapy program offered as a prerequisite for vocational training. When the project ended four patients were referred to outpatient psychiatric facilities, two others refused treatment, and three were considered well enough to continue their vocational program without further counseling.

Findings and Impressions.—By our criterion, 50 percent of our clients were vocationally successful; there was a positive relationship with past ability to keep a job for a consecutive year but none with age, IQ, diagnosis, education, length of incapacitation, previous hospitalization, degree of family disorganization, treatment method, or maintenance of treatment contact. The 50 percent who were successful and an additional 11 percent who shifted from total dependence to partial self-support suggested that this type of psychiatric treatment holds promise.

Highly coordinated effort between rehabilitation personnel is essential; inevitable communication barriers between disciplines must be broken down. Participating counselors were not specialists in mental health work. Engaging a general counselor took advantage of his knowledge of motivational problems applicable to his physically disabled clients. He also has broader employer resources offering greater chance of vocational placement of emotionally disturbed clients.

We realized in retrospect that, in planning the project with VRS, we were not familiar enough with the philosophy and administrative structure of the agency to insure the type of collaboration both the agency and research staff envisioned. We did not realize counselors operate as virtually independent agents with individual criteria for accepting clients and for referring them to the project. Of the total of 75 referrals to our project, 77 percent were made by 21 percent of the counselors. This was unrelated to how many clients the counselor served. For the first six months we did not receive a cross section of the agency's psychiatrically disabled. Some clients were referred out of desperation when resources were exhausted; others were not referred because counselors felt the clients were progressing satisfactorily and injection of an unknown quantity was feared. A control group first used was a deterrent, for counselors wanted service and not "red tape" with no assurance of help.

Our experience suggests that: Psychiatric treatment programs in rehabilitation must be diversified and contain treatment opportunities geared to the changing needs of the patient; an action-oriented, structured group therapeutic technic evokes more positive response from the chronic patient than conventional free-interaction or discussion group psychotherapy; patients evaluated clinically and by the self-concept scale as having the most positive self-concept despite a history of ineffectiveness are poorer risks for rehabilitation than those whose self-concept is more in keeping with reality.

We are convinced that a clinical psychiatric service attached to or within a vocational rehabilitation agency can assume a leading role in the rehabilitation of psychiatric patients. The clinical staff thus could acquire the orientation and skill necessary to communicate and work with chronic patients, vocational counselors, and community resources. The social worker has a key responsibility in interpreting the vocational counselor-psychiatric communications. This is most effectively done when the social worker devotes her major interest to the problems in-

volved in rehabilitation. In short, a psychiatric facility attuned to needs of a vocational rehabilitation agency could offer a functional evaluation of the patient, provide a diversified treatment program, and work closely with patients and counselors in carrying out a rehabilitation plan.

Recommendations.—From our findings, we would recommend:

1. Establishment of psychiatric facilities closely associated with rehabilitation agencies that are thoroughly skilled in: *(a)* the practical appraisal of patients' vocational potential and limitations, and *(b)* working with patients, counselors, and community resources in planning and achieving realistic goals. Administrative arrangements for such facilities would probably differ, depending on the specific situation, but any plan would have to enable the clinical staff to devote special attention and considerable time to this service in order to develop a fully effective working relationship with the agency.

2. Further investigation of: *(a)* standards of acceptance of psychiatric patients for vocational rehabilitation service, *(b)* the family and social attitudes influencing chronicity and dependence, *(c)* motivational patterns of chronic psychiatric patients and attitudes of counselors and clinical personnel influencing effectiveness in working with chronic psychiatric patients, and *(d)* the effectiveness of structured, activity-oriented group and individual therapeutic technics in rehabilitating chronic psychiatric patients. The facilities recommended in (1) above might well conduct these types of investigations along with their rehabilitative function.

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Champaign's Resource Room for Crippled Children

By: **Merle B. Karnes** *(Director, Office of Special Education, Champaign Community Schools, 705 S. New, Champaign, Ill.)*

In: *Newsletter, The Illinois Council for Exceptional Children.* March, 1960. 9:2:1-3.

LAST FALL after several years of preplanning by the school and community groups aided by the State Department of Public Instruction, Champaign began a program for children who are crippled in an array of ways and in varying degrees. School personnel drew upon experience derived from other programs for exceptional children. The crippled were the only group not previously provided with a program. The following basic principles were used as organizational guides:

- Crippled children in many respects are more like their "normal" peers than they are different.
- Each crippled child is unique. There can be no homogeneous class of crippled children.
- A crippling condition in itself should be no barrier to achievement.
- When the crippled child has no environmental stimuli and social contacts comparable to those ordinarily experienced by his normal peers, he cannot be expected to make comparable responses.
- The development of independence, needed for growth, must be stressed. Overprotection fosters dependence and inhibits full development of the child's potential.
- An educational program must be based on the strengths not weaknesses of a child; the approach must be positive not negative.
- Special service should be given only in areas of weakness where special help is indicated.
- The crippled child should be helped to see himself first as a child and to identify with his normal peers. He should think of himself as a first-grade child, for example, rather than as a crippled child, or worse still, as a "poor little crippled child."
- Early identification of the crippled child is essential for full development of the child's potential and so that the home and school can set up common goals for giving him the best possible training.
- Usually the regular curriculum can be followed, although some with perceptual problems need special teaching methods and technics.
- The crippled child can become a useful citizen if his dignity and worth are recognized and his potential exploited.
- Many social and emotional problems have been caused by improper handling instead of the handicap per se.
- A crippled child like all children should be helped to set realistic goals and be held to these goals. He needs to know what is expected of him and that the adults guiding him are consistently strong enough to hold him to standards in keeping with his abilities.
- Like all children he needs love, acceptance, and recognition. Sympathy and pity do not foster the development of good mental health and personal happiness.
- A complete study should be made of each child, and the medical, psychological, social, and educational findings on the child considered. This differential diagnosis is required to insure total planning for the child, using all school and community resources.
- It is important that a plan be formulated to orient the teachers and principal so they will understand each crippled child enrolled. The entire school staff should participate in developing a program that promotes all facets of the child's growth. Insufficient knowledge and understanding can create anxiety and fear, reflected in the attitudes of pupils.
- Orienting all the school's children to the handicapping conditions of crippled children enrolled is important to gain the understanding and acceptance of crippled children's peers.

The Champaign schools decided to organize their program for crippled children on a resource room basis. The crippled child goes from a regular class to the resource room for special help. Programs already operating on this plan for the blind, partially seeing, hard-of-hearing, and secondary deaf children appeared to be psychologically more sound than enrolling the children in a special class and sending them to a regular class for some activities. The major reasons for preferring the resource room are:

- A crippled child enrolled in regular classes identifies with regular teachers and his peers in regular classrooms rather than the special teacher and the handicapped children.
- Regular teachers are in a better position then to help plan a program for the handicapped child. Having the child on her class roll assures the regular teacher that he is her pupil rather than an occasional visitor. It also conveys to her more forcefully that he has many of the same needs as the nonhandicapped.
- The crippled child is set apart less. His feeling of belonging is not undermined, for it is well known that he is a part of the regular class. He starts the day off with his peers in the regular class, is on the class roll, and shares in planning the day's activities.
- Regular children take more interest in and are more accepting of a child who really belongs to their class.

The special teacher works closely with the regular classroom teacher to interpret the needs of the child and to clarify any type of disability. She provides the child with special equipment and materials that will allow him to follow the curriculum of the regular class and engage in regular activities.

The resource room provides the crippled child with:

- *Physical protection.* Doctors prescribe rest periods for some. He is provided with a cot and a quiet place.
- *Guidance.* A crippled child needs help in understanding his particular disability in order to develop a healthy attitude toward himself, to accept his limitations, and to build on his strengths.
- *Tutoring.* Perceptual problems of some crippled children require special teaching methods. Children who have had extended absences may be retarded educationally and may need individual help to "catch up."

Although the program has existed for only six months, special educators, regular educators, and parents seem to feel the resource room plan is the ideal organizational plan for crippled children in the Champaign schools. Long-range planning is in progress. It is hoped in the future that the plan will serve children at the junior and senior high levels and that the grade range will be decreased at the elementary level. The program is unique in its emphasis on normality and appears to promote better mental health. It is a positive approach to the education of crippled children.

Newsletter, The Illinois Council for Exceptional Children is published by the Illinois Council for Exceptional Children, Chapter 118; editor: Gloria Calovini, State Office of Public Instruction, 1130 S. Sixth, Springfield, Ill.

Events and Comments

ISWC and NYU to Offer Third International Prosthetics Course

A SERIES OF two-week courses will be offered from August 15 to 26 by the New York University Post-Graduate School in cooperation with the International Society for the Welfare of Cripples. Held just prior to the Eighth World Congress, the courses will constitute the Third International Prosthetics Course, sponsored by the ISWC Committee on Prostheses, Braces, and Technical Aids. The series will offer courses for physicians and surgeons, for therapists, and for prosthetists. All three courses will include laboratory sessions with amputee patients. The prosthetists will fabricate prostheses. As time permits, lower extremity orthotics (bracing) will be included in the courses. For further information, write to Sidney Fishman, Ph.D., Prosthetics Education, New York University Post-Graduate Medical School, 342 E. 26th St., New York 10, N.Y.

What's New on the Aged

IN *WHAT'S NEW*, published by Abbott Laboratories, North Chicago, Ill., has appeared a series of four articles on "Senior Citizen at the Crossroads." Part IV, on rehabilitation, closed the series in the current, Late Winter, 1960, issue *(No. 216)*. The earlier articles were on health problems *(No. 215)*, housing problems *(No. 214)*, and community responsibilities *(No. 213)*. Colored drawings handsomely illustrated each article.

Council on Education of Deaf Proposed

THE MARCH, 1960, issue of *The Volta Review* (p. 108) published the minutes of a meeting of representatives of the Alexander Graham Bell Association for the Deaf, the American Instructors of the Deaf, and the Conference of Executives of American Schools for the Deaf, held January 20 in Washington, D.C. The purpose of the meeting was to explore areas and ways that the three organizations could cooperate to reach the common goal of better education for deaf children. Formation of a Council on Education was proposed, subject to action by the three organizations.

(Continued on page 172)

Abstracts of Current Literature

This abstracting section, together with other numbered references indexed in this issue, serves as a supplement to the reference book Rehabilitation Literature 1950-1955, *compiled by Graham and Mullen and published in 1956 by the Blakiston Division of McGraw-Hill Book Company, New York. An author index will be found on the last page of the issue.*

AMPUTATION—EQUIPMENT

321. Gaenslen, Frederick G. *(1031 N. Astor St., Milwaukee, Wis.)*

Prosthesis of the hip. *Wis. Med. J.* Mar., 1960. 59:3: 181-184.

Presents a brief history of the development of the artificial hip prothesis. Although most early appliances were not mechanically well designed or made of truly inert material, recent improvements in the prostheses themselves and greater knowledge of surgical technics have resulted in more satisfactory outcome for the patient. Careful selection of patients, indications and contraindications for use of the hip prosthesis, and the complications that may arise postoperatively and in a later stage are discussed.

AMPUTATION—MENTAL HYGIENE

322. Siller, Jerome *(1231 Sheridan Ave., Bronx 56, N.Y.)*

Psychological concomitants of amputation in children. *Child Development.* Mar., 1960. 31:1:109-120.

Data from research surveys conducted by New York University's Prosthetic Devices Studies are analyzed in regard to child amputees' reactions to disability, parental acceptance, social sensitivity, and general adjustment. Of the 52 children studied, 60 percent had adequate or better adjustment, 62 percent had at least average parental acceptance, and 58 percent no more than average sensitivity. The most frequent reactions to disability in this group are discussed.

APHASIA

323. Stoicheff, Margaret L. *(Dept. of Speech Pathology and Audiology, Univ. of Iowa, Iowa City, Iowa)*

Motivating instructions and language performance of dysphasic subjects. *J. Speech and Hear. Research.* Mar., 1960. 3:1:75-85.

Speech behavior of 42 dysphasic persons given three types of motivating instructions on naming and reading tasks was evaluated and findings interpreted to indicate that a psychological factor, anxiety, is present in the symptomatology presented by the dysphasic individual. Those subjected to discouraging instructions, as contrasted to encouraging or nonevaluative instructions, did significantly more poorly on language tasks. Positive attitudes and actions concerning language recovery in the dysphasic should be expressed by all those working and associating with the dysphasic person. The article is based on the author's doctoral dissertation (University of Iowa, 1959).

ARTHRITIS

324. Dawson, J. Euan

Arthritis in animals; a short survey of some of the literature. *Annals Phys. Med.* Feb., 1960. 5:5:163-167.

Although literature on arthritis in domestic animals is available, little is reported concerning joint conditions in wild animals and in zoo animals. The author cites evidence to show that the disease is one of the most ancient known, both in man and animal. Even reptiles and birds do not escape the ravages of arthritis and skeletal deformity.

ARTHRITIS—EMPLOYMENT—GREAT BRITAIN

325. Harris, R. *(Rehabilitation Unit, Devonshire Royal Hosp., Buxton, England)*

Rehabilitation and resettlement in rheumatoid arthritis. *Occupational Ther.* Feb., 1960. 23:2:27-30.

Reprinted from: *Trans.*, Assn. Indust. Med. Officers, Vol. VIII, no. 3.

An analysis of data on more than 1,000 patients with rheumatoid arthritis treated in the Rehabilitation Unit of the Devonshire Royal Hospital, England, over a five-year period indicates that 80 percent can be returned to a useful life and more than 60 percent to some type of work. Careful initial job placement through the resettlement clinic was credited for the success in their rehabilitation. In subjects for whom these services were necessary, 50 percent were still adequately resettled and fully employed after two years. Problems in the rehabilitation of rheumatoid arthritis patients are reviewed.

BLIND—SOCIAL SERVICE

See 317.

BLIND—SPECIAL EDUCATION

326. New York. Bureau for Handicapped Children

The challenge of educating the blind child in the regular classroom: a pictorial story of blind children attending school with sighted children. Albany, N.Y. State Education Dept., 1960. 16 p. illus.

Many illustrations of blind children successfully attending school with sighted children are interspersed in the text. The problem of educating the blind child in regular classes is not *what* to teach but how to present subject matter more effectively. Discussed are technics for use in kindergarten and elementary grades, contribution of the home and voluntary workers, and some characteristics of the blind child with which the teacher should be familiar.

Available from Dr. Erbert F. Cicenia, Edward R. Johnstone Training and Research Center, Bordentown, N.J., or from the New York State Bureau for Handicapped Children, Albany, N.Y.

See also 312.

BLIND—STATISTICS

327. Patterns of Disease. Mar., 1960.

Special report: Eye disorders.

Gives statistics on the estimated prevalence of blindness and visual impairment in relation to other disabilities, types of workers wearing glasses, major types of industrial eye injuries, causes of blindness, and preventive management. A table of yearly placements of blind clients from a state rehabilitation program illustrates the employment possibilities for this group.

Patterns of Disease is published monthly by Parke, Davis & Co., Detroit 32, Mich.

BRACES

328. Becker, Folke *(V.A. Hospital, Dublin, Ga.)*

Self-help prosthetic device to facilitate locking and unlocking of long-leg braces. *Arch. Phys. Med. and Rehab.* Mar., 1960. 41:3:111-112.

Describes a device called the "Boomerang" that enables the paraplegic to lock and unlock his long-leg braces without assistance. Patients using short-leg braces can also use the device to perform active assistive exercise of a weak lower extremity. Construction details of the leg extension device are given. Its advantages are its light weight, low cost, and extremely rugged construction requiring little or no repair over years of continuous use.

329. Sterling, Harold M. *(Dept. of Phys. Med. and Rehab., Univ. of Minnesota, Minneapolis 14, Minn.)*

Constant tension springs on long leg braces to assist the quadriceps femoris, by Harold M. Sterling and Frederic J. Kottke. *J. Am. Med. Assn.* Mar., 1960. 172:12:1268-1270.

Describes the design and manufacture of a long-leg brace with constant-tension knee-extension supports for the patient whose quadriceps are too weak when the knees are extended. Four case histories illustrate the value of the brace in promoting ambulation and in strengthening the weak muscles through use.

See also 385.

BRAILLE

330. Henderson, Freda *(Tennessee School for the Blind, Donelson, Tenn.)*

Little pumps that say something. *Exceptional Children.* Jan., 1960. 26:5:261-266.

Some guidelines for teachers of children who are blind, concerning the proper time to begin the teaching of Braille, how soon the blind child should be introduced to contractions in Braille, and how much Braille reading can be expected of the blind child. Classroom technics for providing the blind child with experiences to develop social, emotional, mental, and physical maturity are discussed.

BRAIN INJURIES—PSYCHOLOGICAL TESTS

331. Blau, Theodore H. *(539 Madeira, Davis Islands, Tampa, Fla.)*

The Spiral Aftereffect Test (SAET) as a predictor of normal and abnormal electroencephalographic records in children, by Theodore H. Blau and Robert E. Schaffer. *J. Consulting Psych.* Feb., 1960. 24:1:35-42.

Presents a brief review of the literature concerned with evaluation of the Spiral Aftereffect Test and gives findings of the authors' study of the effectiveness of the technic in predicting abnormal and normal EEG findings in children. The test was considered the best of a series of psychological technics for this purpose. It is their belief that the SAET, when used in combination with one or more standard psychological tests, provides more accurate and valid data.

CEREBRAL PALSY

332. Holt, Kenneth S. *(Univ. of Sheffield, Sheffield, England)*

Mentally handicapped children with cerebral palsy; the problems of home care. *Spastics Quart.* Mar., 1960. 9:1: 4-12.

In same issue: The mentally handicapped child with cerebral palsy in a special institution, Marguerite N. Mennie, p. 13-22.—Cerebral palsy and mental handicap; research aspects, Brian H. Kirman, p. 23-35.

Three articles concerned with various aspects of the care and treatment of the cerebral palsied in whom motor defects are combined with mental handicaps. Dr. Holt offers his personal observations of the serious problems confronting the parents and families of such children being cared for at home. Miss Mennie discusses the problems and advantages of lengthy institutional care in a special residential center, based on her experiences at Stanmore House, Lanark, Scotland. Dr. Kirman, Director of Research at Fountain Hospital (London, S.W. 17, England), describes progress made in cerebral palsy research in recent years, stressing the need for coordination of effort throughout the entire field. A comprehensive survey should be made, he believes, of the cerebral palsied with mental defects.

CEREBRAL PALSY—DIAGNOSIS

333. Courville, Cyril B. *(1200 N. State St., Box 76, Los Angeles 33, Calif.)*

Structural Alterations in the cerebellum in cases of cerebral palsy; their relation to residual symptomatology in the ataxic-atonic group. *Bul.*, Los Angeles Neurol. Soc. Sept., 1959. 24:3:148-165.

Eight cases of cerebellar alterations in a series of 126 cases of cerebral palsy were verified at autopsy; data from five are reported in some detail. An outline of the lesions found in this series of cases is included, with a brief description of the individual changes. Cerebellar symptoms are infrequent and insignificant in contrast to the pyramidal and extrapyramidal manifestations, which may obscure or neutralize any symptoms of cerebellar origin. More attention should be paid to these lesions. Dr. Courville believes, in view of clinical symptomatology in cerebral palsy before final conclusions can be drawn in regard to their full significance.

CEREBRAL PALSY—MEDICAL TREATMENT

334. Gillette, Harriet E. *(Univ. of Florida Coll. of Medicine, Gainesville, Fla.)*

Changing concepts in the management of neuromuscular dysfunction. *South. Med. J.* Oct., 1959. 52:10:1227-1229.

A review of the methods of treatment of neuromuscular dysfunction for the cerebral palsied patient; emphasis is on the relationship of changes in systems of treatment to medical and social changes. The evolution of antibiotic drugs and electronic instruments has suggested new avenues of research. In Dr. Gillette's opinion the principle of treating manifestations of the disease rather than the theory of their pathogenesis should be followed. Worthwhile features of all the systems outlined should be combined to treat the individual patient as a whole person.

335. Illingworth, R. S. *(Univ. of Sheffield, Sheffield, England)*

A double blind trial of "Soma" in cerebral palsy, by R. S. Illingworth (and others). *Spastics' Quart.* Mar., 1960. 9:1:34-38.

A report of an experimental trial of a new muscle relaxant (Soma) and results of its use with 31 spastic and 16 athetoid children. Under conditions of the trial described here, the authors state unequivocally that the drug exerted no beneficial effect. Reports of trials of the drug by Dr. Phelps and Catherine E. Spears appeared in the June and July, 1959, issues of the *Archives of Pediatrics* (see *Rehab. Lit.*, Jan., 1960, #30, 31).

CEREBRAL PALSY—PROGRAMS

336. Burk, Richard D. *(Ohio Rehabilitation Center, Ohio State University, Columbus, Ohio)*

Serving the cerebral palsied adult, by Richard D. Burk and James P. Zimmerman. *J. Rehab.* Jan.-Feb., 1960. 26: 1:7-9.

Programs of service for the adolescent and adult cerebral palsied should employ a different approach than those that are child-centered. Complete medical evaluation is necessary but the psychological, social, and vocational needs of clients must be served. Goals should be realistic, recognizing the client's self-concepts in the counseling process. The authors believe that some of the funds now spent on therapeutic programs for children might be put to better use in the establishment of sheltered workshops and residences for adult cerebral palsied.

CEREBRAL PALSY—SPECIAL EDUCATION

See p. 151.

CHILDREN'S HOSPITALS

337. American Academy of Pediatrics *(1801 Hinman Ave., Evanston, Ill.)*

Care of children in hospitals. Evanston, Ill., The Academy, c1960. 96 p. floor plans, forms.

A manual prepared by the Academy's Committee on Hospital Care to aid those planning hospital construction and organizing and operating a pediatric service in the community hospital. It is the outgrowth of a special report under the same title that was published as a supplement to the Oct., 1954 issue of *Pediatrics*. (See *Bul. on Current Lit.*, Nov., 1954, #1116.) The information is geared to the 20-bed pediatric unit of the average community hospital. Discussed are responsibilities of the general hospital in child care, personnel, the physical plant, medical and nursing services, communicable disease technics, nutrition, and psychological needs of child patients.

CHRONIC DISEASE—INSTITUTIONS

338. What is needed in planning for long-term care. *Modern Hosp.* Mar., 1960. 94:3:79-102, 162.

Contents: Hospitals should coordinate services for long-term care, Helen L. Knudsen.—Long-term care poses special problems for administrators, David Littauer.—Ten architects offer 11 plans for long-term facilities.—The architect's task; make a home out of a nursing home, Emerson Goble.—F.H.A. tells nursing homes how to apply for mortgage insurance, Julian H. Zimmerman.

Floor plans, illustrations, cost figures, and brief descriptions of some facilities built in recent years in the United States and Europe are included.

CHRONIC DISEASE—PROGRAMS

339. National Health Council

Research in patient care (with special emphasis on comprehensive care of the chronically ill and aging); a report on a meeting of the Committee on Research of the ... January 19, 1960. New York, The Council, 1960. 36 p.

Reports are summarized on three research projects in patient care—at the New York Hospital-Cornell Medical Center, at Thayer Hospital, Waterville, Me., and the U.S. Public Health Service project in comprehensive care. Discussions following each presentation are included. The report also contains the full text of the papers presented: Nursing needs of elderly, chronically ill, ambulatory patients, by Doris Schwartz.—Progressive patient care; the core of a community health center, by Faye G. Abdellah.—The comprehensive care program at Thayer Hospital, Waterville, Maine, by Harold N. Willard.

Available from the National Health Council, 1790 Broadway, New York 19, N.Y., at 75¢ each.

340. Peterson, Paul Q. *(Natl. Institutes of Health, Bethesda, Md.)*

The Health department's responsibility in chronic disease programs. *Am. J. Public Health.* Feb., 1960. 50:2: 134-139.

Newer programs of chronic disease prevention and control are merely an expansion of older and well-established programs. The only new problems to be dealt with are the wide range of disease entities included in current programs and the necessity for specific technics to be used in detecting particular diseases or conditions. Five examples of successful programs illustrate ways in which chronic disease activity can be implemented. The author urges greater attention to public health education and applied research in the field of chronic disease.

CLEFT PALATE—PARENT EDUCATION

341. Goodstein, Leonard D. *(East Hall, Univ. of Iowa, Iowa City, Iowa)*

MMPI differences between parents of children with

cleft palates and parents of physically normal children. *J. Speech and Hear. Research.* Mar., 1960. 3:1:31-38.

In same issue: Personality test differences in parents of children with cleft palates, Leonard D. Goodstein, p. 39-43.

Performance on the Minnesota Multiphasic Personality Inventory test by 170 mothers and 157 fathers of children with cleft palate were interpreted as indicating that they did not differ in any important way from the control group.

Dr. Goodstein's second article describes an attempt to relate parental adjustment to such clinical factors as age of the child, type of cleft, rated social adjustment of the child, and each parent's adequacy in handling the child. Ratings of parental adjustment were obtained as described in Dr. Goodstein's first article above; these were found to be of little help, however, in understanding parents on a theoretical level or in making practical decisions relating to program planning for treatment.

CLEFT PALATE—PROGRAMS

342. Kobes, Herbert R. *(Dr. Pruzansky, 64 Old Orchard, Skokie, Ill.)*

The cleft palate team; a historical review, by Herbert R. Kobes and Samuel Pruzansky. *Am. J. Public Health.* Feb., 1960. 50:2:200-205.

Traces the growth of the team concept in the treatment of persons with cleft palate, the founding of the American Association for Cleft Palate Rehabilitation, and some of the persons instrumental in advancing cleft palate treatment to its current status. Research conducted in the Cleft Palate Training Program, of which Dr. Pruzansky is associate director, is discussed.

DAY CAMPING

343. Spear, Dorothy *(4370 Olive St., St. Louis 8, Mo.)*

Daniel Boone roams again—when the severely handicapped go day camping. *Recreation.* Mar., 1960. 53:3: 116-118.

Describes the program, facilities, and benefits of day camping experiences provided at Daniel Boone Camp by the St. Louis Society for Crippled Children. It has been demonstrated that children with many different diagnoses, including blindness and epilepsy, can be integrated successfully in the camping program as long as groups are small, the program flexible, and the staff adequately prepared.

DEAF-BLIND—SOCIAL SERVICE

344. American Foundation for the Blind

Social group work with deaf-blind adults, by Donna Verstrate. New York, The Foundation, 1959. 55 p. *(No. 1, Social Welfare ser.)*

In this adaptation of a master's thesis (New York School of Social Work), the writer describes her experiences in applying social group work principles to a one-night-a-week recreation program serving 22 deaf-blind men. The program is described and its development over a five-month period evaluated. Findings of the study and their implications for future work with deaf-blind persons, for the training of volunteers, and for adapted activities of such programs are discussed.

Available from American Foundation for the Blind, 15 W. 16th St., New York 11, N.Y., at 75¢ a copy.

EMPLOYMENT (INDUSTRIAL)

See 313.

EPILEPSY—EMPLOYMENT

345. U.S. Department of Veterans Benefits

Occupations of epileptic veterans of World War II & Korean conflict; prepared by Rolland W. Norris. Washington, D.C., Govt. Print. Office, 1960. 62 p. *(VA pamph. 22-6)*

Described as the "first major study ever published of the employment experiences of veterans with epilepsy," this pamphlet presents brief case studies of persons employed in a wide variety of jobs ranging from professional to manual labor. This is the third such study issued by the Veterans Administration; others in the series presented findings for blinded and paraplegic veterans. (See *Rehab. Lit.*, Nov., 1957, #1315, and Nov., 1956, #1308.) All are intended primarily for use by VA personnel engaged in the vocational rehabilitation of veterans with similar problems.

EPILEPSY—ETIOLOGY

346. Eisner, Victor *(970 Corbett Ave., San Francisco 14, Calif.)*

Epilepsy in the families of epileptics, by Victor Eisner, Lydia L. Pauli, and Samuel Livingston. *J. Pediatrics.* Mar., 1960. 56:3:347-354.

A statistical survey of the families of 699 epileptic and 470 control patients was conducted at the seizure clinics of Johns Hopkins Hospital in an effort to determine genetic aspects of convulsive disorders. Findings revealed a small but significant familial aggregation of idiopathic major motor epilepsy that appeared to vary with the age of proband at onset of epilepsy. No familial aggregation could be demonstrated when age of onset was over 15½ years, or in any other type of epilepsy. Possible causes for such aggregation in this type of epilepsy are considered. Hereditary transmission of epilepsy could not be demonstrated but the possibility could not be ruled out. Risk tables for chances of relatives of patients with idiopathic major motor epilepsy developing epilepsy are included. Simple febrile convulsions were not included in this study.

EXERCISE

347. Freedland, R. R. *(Medical Rehabilitation Centre, Camden Rd., London, England)*

Keeping old people active, by R. R. Freedland and H. C. Faulkner. *Med. World.* Feb., 1960. 92:2:146-148.

Some 30 residents of an old ladies' home in London voluntarily attend "keep-fit" classes held twice weekly. Conducted by a remedial gymnast, activities are simple and require very little equipment (a large room, straight backed chairs, and a gramaphone are sufficient). Exercises done in "follow-the-leader" fashion are mainly of the free swinging type, performed in both the standing and sitting positions. The authors believe the class serves an important preventive role in chronic disability.

HEART DISEASE—DIAGNOSIS

348. American Medical Association, Committee on Medical Rating of Physical Impairment

Guides to the evaluation of permanent impairment; the cardiovascular system. *J. Am. Med. Assn.* Mar. 5, 1960. 172:10:1049-1060.

Another of the practical guides for rating degree of disability in various types of permanent impairment, prepared by the American Medical Association to define the scope of medical responsibility. For practical purposes cardiovascular impairment is subdivided into three categories: heart disease, hypertensive vascular disease, and vascular diseases affecting the extremities. Methods for determining degree of disability in each category are discussed in detail.

Mr. George W. Cooley *(Am. Med. Assn., 535 N. Dearborn St., Chicago 10, Ill.)* is Secretary of the Committee on Medical Rating of Physical Impairment.

HEART DISEASE—EMPLOYMENT

349. Becker, Marvin C. *(Cardiac Clinic, Beth Israel Hosp., Newark, N.J.)*

Work prescription for the disabled cardiac. *J. Rehab.* Jan.-Feb., 1960. 26:1:4-6, 44.

A discussion of the physician's role in rehabilitation of the cardiac patient, his methods for evaluating the patient's work potential, and some of the factors that may influence the work prescription planned for the individual's needs.

HEART DISEASE—RESEARCH

350. Chicago Heart Association

Heart research in industry (proceedings of the Seventh Heart-in-Industry Conference, Chicago, 1959). Chicago, The Assn., 1960. 48 p. illus.

Sponsored jointly by the Chicago Heart Association and the Chicago Association of Commerce and Industry, the Seventh Conference brought together industrial management and labor union leaders with members of the medical profession. In their discussions are reported scientific in-plant investigations being conducted to determine factors associated with heart disease in the man-on-the-job. Discussions of six workshop sessions concerned with the practical aspects of research undertaken by industry are also digested. Topics covered in the previous six conference meetings are mentioned briefly in the preface of the booklet.

Copies available from Louis De Boer, Chicago Heart Assn., 22 W. Madison St., Chicago 2, Ill., or from Jesse A. Jacobs, Chicago Assn. of Commerce and Industry, 30 W. Monroe St., Chicago, Ill.

HEMIPLEGIA—PHYSICAL THERAPY

See 366.

HYDROCEPHALUS

351. Ransohoff, Joseph *(Neurological Institute, 710 W. 168th St., New York 32, N.Y.)*

Hydrocephalus; a review of etiology and treatment, by Joseph Ransohoff, Kenneth Shulman, and Robert A. Fishman. *J. Pediatrics.* Mar., 1960. 56:3:399-411.

A summary of current knowledge of hydrocephalus, with an outline of newer and more controversial theories in regard to the dynamics of cerebral spinal fluid circulation. In spite of reports of a high incidence of spontaneous arrest in untreated hydrocephalus, the authors believe that surgical therapy should be employed to achieve maximum intellectual and cosmetic results. 62 references.

MEDICINE (INDUSTRIAL)

See 313; 316.

MENTAL DEFECTIVES

See 332; 359.

MENTAL DEFECTIVES—SPECIAL EDUCATION

352. U.S. Office of Education

The retarded child goes to school; prepared by Harold M. Williams. Washington, D.C., Govt. Print. Off., 1960. 24 p. *(Pamph. No. 123; OE-35000)*

A pamphlet intended for the layman, giving brief and general statements on the retarded child, his educational needs, and the major ways in which schools are attempting to meet both the educational and social requirements of these children. Includes a brief list of selected references.

Available from U.S. Superintendent of Documents, Government Printing Office, Washington 25, D.C., at 15¢ a copy.

See also 364.

MENTAL DEFECTIVES—SPECIAL EDUCATION—CALIFORNIA

353. California. State Department of Education

Education of mentally retarded minors in the public schools of California; compiled and prepared by Flora M. Daly and Robert A. Henderson. Sacramento, The Dept., 1959. 71 p. illus., figs. *(Bul., Calif. State Dept. of Educ. Oct. 1959. 28:8.)*

The second revision of a bulletin published in 1950 under the title *Questions on the Education of Mentally Retarded Minors in California* and brought up to date to reflect legislative and program changes. Public school administrators and teachers should find it a source of reference in understanding the legal provisions, organization, and teaching methods for special training classes for both the educable and severely retarded. Contains an eight-page bibliography.

Available from State Department of Education, Bureau of Textbooks and Publications, Sacramento 14, Calif., at 50¢ a copy.

MENTAL DISEASE—PROGRAMS

354. Rockmore, M. J. *(Connecticut State Dept. of Mental Health, Hartford 15, Conn.)*

Community planning as a support to treatment, by M. J. Rockmore and Elias J. Marsh. *Amer. J. Psychiatry.* Feb., 1960. 116:8:723-728.

Because of the limited tax funds available and the serious shortage of trained personnel, coordination of all resources for treating mental illness must be accomplished. Planning can begin with the individual physician and his recognition of the needs of individual patients. Communication of the accumulated needs of

many mentally ill persons can lead to broad policy planning for programs that utilize all available resources.

See also 318; p. 142.

MULTIPLE SCLEROSIS—MEDICAL TREATMENT

355. Watson, C. Wesley *(171 Harrison Ave., Boston 11, Mass.)*

Effect of lowering of body temperature on the symptoms and signs of multiple sclerosis. *N. Eng. J. Med.* Dec. 17, 1959. 261:1253-1259.

Lowering of body temperature in eight patients with multiple sclerosis resulted in some improvement in signs and symptoms of the disease; improvement lasted, however, only as long as body temperature remained lowered. No evidence was observed of any lasting effect of this type of treatment on the severity of multiple sclerosis. Repeated cooling is necessary for maintenance of relief. Technics for lowering body temperature are discussed.

MUSCLES—TESTS

356. Close, J. R. *(2929 Summit St., Oakland, Calif.)*

Electromyography; its application in orthopaedic surgery. (17) p.

In *Am. Acad. of Orthopaedic Surgeons, Instructional Course Lectures.* Ann Arbor, J. W. Edwards, Publ., 1959. Vol. 16, p. 246-262.

A detailed article on the use of electromyography in neurodiagnosis and the study of muscle function and locomotion. Some attention is given to basic neuroanatomy and the composition of the motor unit. Technics and equipment employed in recording the action potential of muscles are described. Such tests have great supplemental value in differential diagnosis in neurological conditions.

MUSIC THERAPY

See 315.

MYASTHENIA GRAVIS

357. Magee, Kenneth R. *(1313 E. Ann St., Ann Arbor, Mich.)*

Myasthenia gravis. *Am. J. Nursing.* Mar., 1960. 60:3: 356-339.

In same issue: Nursing care of the myasthenic patient, Doris Moser, p. 340-343.

A general review of the disease, its symptoms, associated disorders, and definitive diagnosis. Drugs used in its management and the proper treatment of the "myasthenic crisis" are discussed. According to Miss Moser *(Univ. of Michigan School of Nursing, Ann Arbor, Mich.)*, understanding of the medication required, care during crisis, educating the patient on all aspects of self-care at home, and offering emotional support are requirements for good nursing care.

NERVE INJURIES

358. Seddon, H. J. *(Institute of Orthopaedics, University of London, London, England.)*

Peripheral paralysis. *Physiotherapy.* Feb., 1960. 46:2: 34-39.

Of the many conditions causing peripheral paralysis, Dr. Seddon chose to discuss the similarities found among three—poliomyelitis, nerve injuries, and leprosy. In addition to the tendency to produce deformity, all three are characterized by nerve degeneration. Treatment for the prevention of contractures and the re-education of muscles is considered briefly.

NUTRITION

359. Centerwall, Willard R. *(Coll. of Med. Evangelists, 1720 Brooklyn Ave., Los Angeles 33, Calif.)*

Phenylketonuria. *J. Am. Dietetic Assn.* Mar., 1960. 36:3:201-205.

In same issue: Phenylketonuria; dietary management, Phyllis Brown Acosta and Willard R. Centerwall, p. 206-211.

Briefly discusses the historical background, incidence, and clinical symptoms of phenylketonuria, as well as the relation of the metabolic defect to mental deficiency. A more detailed review of the role of diet in the treatment of the condition and in the prevention of mental deficiency is included. Some simple routine detection tests useful in diagnosing phenylketonuria early in infancy are described. 32 references. Dr. Centerwall is conducting research in the detection and management of phenylketonuria with the aid of a grant from the National Institutes of Health.

Miss Acosta (*same address*) and Dr. Centerwall offer special low-phenylalanine recipes, stressing that diet in such patients must be carefully controlled and the special diet instituted as early as the fourth to sixth week of infancy, to be maximally effective.

OCCUPATIONAL THERAPY

See 314.

OLD AGE—MEDICAL TREATMENT

360. Watren, Marjory W. *(West Middlesex Hosp., Isleworth, Middlesex, England)*

Rehabilitation of the elderly patient. *Annals Phys. Med.* Feb., 1960. 5:5:170-181.

A comprehensive discussion of the conditions liable to affect older persons and the preventive and active treatment of disabilities necessary to achieve rehabilitation in the elderly patient. A very personal approach is needed in working with the elderly person who is ill; the physician should also be aware of the effects of social conditions on the physical or mental state of persons in this age group. Some consideration is given to the use of aids and adapted equipment in keeping the elderly active and independent.

OLD AGE—RECREATION

See 347.

ORTHOPEDICS—BIOGRAPHY

See 316.

PAIN

361. Jacobs, Miriam *(Camp Meeting Rd., Lee Hall, Pa.)*

Massage for relief of pain; anatomical and physiological

considerations. *Phys. Therapy Rev.* Feb., 1960. 40:2: 93-98.

In same issue: Pain and exercise, Helen J. Hislop, p. 98-106.—Heat for the relief of pain, Rachel H. Adams, p. 106-111.—The physiological effects of cold applications, Alma J. Murphy, p. 112-115.—Mechanisms of pain relief as a result of therapeutic application of ultrasound, Alfred J. Szumski, p. 116-120.

In this group of papers presented at the 1959 annual conference of the American Physical Therapy Association, the authors have discussed various forms of therapy used in the relief of pain. All contain, as well, explanations of the mechanisms of pain, muscle spasm, contractures, and ischemia and the effect of various forms of therapy in relieving such conditions. (Addresses of the other authors are: Miss Hislop, University of Iowa, Iowa City, Iowa; Capt. Adams, AMSC, Ft. Sam Houston, Texas; Dr. Murphy, 11833 Four Lakes Dr., South Lyons, Mich.; and Mr. Szumski, Medical College of Virginia, Richmond, Va.)

PARAPLEGIA—EQUIPMENT

See 328; 385.

PARAPLEGIA—MENTAL HYGIENE

362. **Rosenblatt, Aaron** *(V.A. Hospital, Bronx 68, N.Y.)*

Evaluating a medical symptom with paraplegics, by Aaron Rosenblatt and Vincent W. Trovato. *Soc. Casework.* Mar., 1960. 41:3:128-134.

Special attention is given the problem of decubitus ulcer and the psychosocial factors that can, in many instances, account for the existence of the ulcer. Social workers need an understanding of the actual medical problems of the paraplegic in order to evaluate the interaction of all factors in the patient's motivation for rehabilitation. Reactions and adaptation to disability are expressed in a variety of ways by paraplegic patients; it must be recognized that they can exercise a large measure of control over their medical problems if properly motivated.

PARENT EDUCATION

363. **Denhoff, Eric** *(293 Governor St., Providence 6, R.I.)*

The impact of parents on the growth of exceptional children. *Exceptional Children.* Jan., 1960. 26:5:271-274.

Physicians should recognize that parents of handicapped children have the same basic feelings for their children as parents of normal children have for theirs. Adverse influences on the growth and development of the child often can be traced to anxieties of the mother that appear early in pregnancy and distort the mother-child relationship following birth. Distorted beliefs in regard to childhood behavior can adversely affect the child's future adjustment. It has been found, however, that physical handicap alone has never deterred normal adjustment. The emotionally healthy family can successfully raise happy and well-adjusted children in spite of physical handicaps.

PARTIALLY SIGHTED

See 372.

PHYSICAL EDUCATION

364. **Shotick, Andrew** *(Syracuse Univ., Syracuse, N.Y.)*

Reactions of a group of educable mentally handicapped children to a program of physical education, by Andrew Shotick and Charles Thate. *Exceptional Children.* Jan., 1960. 26:5:248-252.

Level of enthusiasm for each activity of the program, individual response to instruction, and response of each child to others in the group were evaluated in seven of the eight children in the intermediate class for educable mentally handicapped children at the University School of Southern Illinois University. Findings should have implications for the development of physical education programs for such children and should suggest areas for work in social adjustment.

PHYSICAL MEDICINE—PERSONNEL

365. **Bennett, Robert L.** *(Warm Springs Foundation, Warm Springs, Ga.)*

The Ninth John Stanley Coulter Memorial Lecture: Tomorrow's physiatrist. *Arch. Phys. Med. and Rehab.* Mar., 1960. 41:3:89-94.

In contrast to the role of the physiatrist of the past, the physiatrist of the future will be oriented in the concept of total rehabilitation, but his responsibility will be the over-all care of a well-defined group of diseases primarily affecting the neuromuscular and musculoskeletal systems. He will call on the advice and skills of other medical and surgical specialists and of members of paramedical professions to insure adequate care of his patients. Dr. Bennett traces the impact of medical advances and the rehabilitation concept on the growth of physical medicine as a specialty.

PHYSICAL THERAPY

366. **Stewart, Margaret A.**

Physiotherapy in medical and social rehabilitation; illustrated by treatment of patients with fractures of the femoral neck and hemiplegia, by Margaret A. Stewart and Elvira P. G. Hobson. *Physiotherapy.* Mar., 1960. 46:3:69-74.

Medical rehabilitation alone is not sufficient to return patients in these categories to independent living at home. Physical therapy should concentrate on the teaching of basic activities essential to personal independence. The authors discuss the problems often posed by conditions found in the home; modifications can be suggested by the therapist to aid the patient in daily living activities. Adequate after-care and cooperation of family members can insure maximum results in rehabilitation of these patients.

See also 310.

POLIOMYELITIS—MEDICAL TREATMENT

367. **Allbrook, David** *(Makerere College Med. School, Uganda, E. Africa)*

Surgical relief of severe paralytic hip contracture, by David Allbrook and H. Fletcher Lunn. *Lancet.* Feb. 27, 1960. 7122:459-461.

A report of the favorable results of surgery (multiple subcutaneous division of the fascia lata) in relieving

the severely crippling deformity resulting from untreated anterior poliomyelitis in Uganda. Major surgery was avoided in 32 African children so treated; all have had one or both of their hip contractures corrected. Following the operation, walking instructions, fitting and maintenance of calipers, and home instruction have aided all in becoming ambulant. Technics of the operation are described.

POLIOMYELITIS—PHYSICAL THERAPY

368. Green, V. M. *(Radcliffe Infirmary, Oxford, England)*

An artificial respiration unit. *Physiotherapy.* Mar., 1960. 46:3:66-68.

Describes the Radcliffe Respiration Pump, devised by Dr. Ritchie Russell and Dr. Edgar Schuster in 1953. Supplying intermittent positive pressure, the pump was originally intended for use with poliomyelitis patients. It has been found useful, also, with patients suffering respiratory distress caused by a variety of conditions. Respirator and nursing care in an artificial respiration unit are discussed in some detail.

369. Prior, L. M. *(Royal Natl. Orthopaedic Hosp., Stanmore, England)*

The treatment of poliomyelitis from an orthopaedic aspect. *Physiotherapy.* Feb., 1960. 46:2:39-47.

Physical therapy technics used in the treatment of poliomyelitis following recovery from the acute stage of the disease are illustrated and described. Discussion of massage and electrical treatment are omitted since these forms of treatment are not employed. Suspension therapy is used to some extent but has been found less valuable than facilitation technics and pool therapy. This is the fourth and last of a series of articles on the treatment of poliomyelitis. Others appeared in the October, November, and December, 1959 issues of *Physiotherapy.* (See *Rehab. Lit.,* Jan., 1960, #55 and 56; and Mar., 1960, #204.)

PSYCHOLOGY

370. Murstein, Bernard I. *(Dept. of Psychology, Univ. of Portland, Portland 3, Ore.)*

The effect of long-term illness of children on the emotional adjustment of parents. *Child Development.* Mar., 1960. 31:1:157-171.

Findings of a study conducted at the University of Texas M. D. Anderson Hospital and Tumor Research Institute showed that emotional adjustment of parents was correlated with their educational and socioeconomic status. Parents of children with leukemia were compared with mothers and fathers of children having some other type of tumor growth requiring extensive hospitalization. Interpersonal relationships played a stronger role in determining adjustment for the leukemias than for the other diseases. Methods of the study are discussed.

PUBLIC ASSISTANCE

371. Hess, Arthur E. *(Bur. of Old-Age and Survivors Insurance, U.S. Social Security Admin., Baltimore, Md.)*

The Old-Age and Survivors Insurance disability program; what disability benefits mean to people. *Am. J. Public Health.* Feb., 1960. 50:2:140-147.

Discussion, Jean Spencer Felton, p. 147-150.—Discussion, Pearl Bierman, p. 150-153.

An evaluation of the operation, achievements, and drawbacks of the disability provisions of the OASI program and the implications of the findings for future operation of the program and for the provision of community health and related services. Dr. Felton (*Univ. of California Graduate School of Public Health, Los Angeles 24, Calif.*) considers the role of the physician in the determination of disability and points out barriers to employment of the disabled ineligible for permanent benefits. Miss Bierman (*1313 E. 60th St., Chicago 37, Ill.*) views the negative and positive aspects of the Disability Insurance program from the standpoint of the public welfare agency.

READING

372. Nolan, Carson Y. *(Am. Printing House for the Blind, 1839 Frankfort Ave., Louisville 6, Ky.)*

A study of pictures for large type textbooks. *Internatl. J. Educ. of the Blind.* Mar., 1960. 9:3:67-70.

A description of the development and evaluation of a method for reproducing colored illustrations legibly in black and white for use in large type textbooks for the visually handicapped. A tracing consisting of a line drawing with areas blacked in for contrast was judged to be more legible than three other types of tracings of the same picture reproduced by the photo-offset method.

RECREATION

373. Rusk, Howard A. *(400 E. 34th St., New York 16, N.Y.)*

Therapeutic recreation. *Hosp. Management.* Apr., 1960. 89:4:35-36.

In same issue: Recreation counseling, Frances B. Arje, p. 36-37.—Recreation in a hospital center, Randolph A. Wyman and Norma Alessandrini, p. 37-39.—A coordinated recreation program in a rural community for the chronically ill, Beatrice H. Hill and Philip Walsh, p. 39-41.—Recreation in a rehabilitation center for children, Betsy Thomas, p. 42-43, 128.

Modern rehabilitation programs are incomplete without the inclusion of recreation services in the total process, Dr. Rusk believes. Such activities should provide the patient with opportunity for social and emotional development. Other articles published in this issue of *Hospital Management* describe the recreational counseling program initiated by the V.A. Hospital of Kansas City; Bellevue Hospital Center's recreation services to patients in a general acute hospital; Sussex County, New Jersey's services for chronically ill institutionalized patients; and recreational activities of the Children's Division of New York's Institute of Physical Medicine and Rehabilitation.

REFUGEES

374. Handicapped refugees. *Lancet.* Feb. 13, 1960. 7120:391.

A brief summary of a recent discussion in Britain's House of Lords concerning the admission to Great Britain of refugees who are ill or handicapped. A plea was made for less stringent regulations and more provisions for care

of those desperately in need of resettlement. Handicapped refugees in camps in Austria, Germany, and Italy number some 10,000, comprising families of which one member is handicapped; the number outside camps is 17,850.

REHABILITATION—ALABAMA

See 311.

REHABILITATION—POLAND

375. **Hulek, Aleksander**

Le système de réadaptation des invalides en Pologne. *Bul. Féd. Internatl. des Mutilés et Invalides du Travail et des Invalides Civils.* Sept., 1959. 3:3:63-74.

Text in French; résumés in English, German, and Italian.

Following World War II Poland was faced with a tremendous problem of providing social benefits for its war wounded, invalids, and orphans, the unemployed and illiterate. The development of vocational rehabilitation was integrated in the country's program of reconstruction. Dr. Hulek has summarized results and methods of 10 years' work of the Congrès des Coopératives d'Invalides Polonais.

REHABILITATION—LEGISLATION

376. **Whitten, E. B.** *(Natl. Rehabilitation Assn., 1025 Vermont Ave., Washington 5, D.C.)*

State legislation, 1959. *J. Rehab.* Jan.-Feb., 1960. 26:1:16-18, 20.

A summary of the most significant laws affecting rehabilitation of the handicapped that were passed by the various state legislatures during 1959. Information was submitted mainly by state directors of vocational rehabilitation and covered basic legislation affecting general rehabilitation programs, legislation for the blind, and miscellaneous acts directed at special education provisions, welfare of the mentally retarded and mentally ill, employment of the physically handicapped, and workmen's compensation.

REHABILITATION—PROGRAMS

377. **Hartford Rehabilitation Center** *(2 Holcomb St., Hartford 12, Conn.)*

A follow-up study of patients discharged from a community rehabilitation center . . . Project director, David D. Komisar. Hartford, Conn., The Center, 1960. 86 p. tabs. *(Off. of Voc. Rehabilitation . . . Project 328)*

Progress of 350 patients discharged from the Hartford Rehabilitation Center during 1955 and 1956 was evaluated in this study supported by a grant from the Office of Vocational Rehabilitation. Similar studies emanating from community rehabilitation centers have been limited in number. The extensive data, including information on patient characteristics, psychosocial factors, and types of disability and treatment, should be of value to rehabilitation agency personnel planning evaluation of their respective programs. Age, disease, and disability were factors apparently related to the maintenance of gains after discharge. Findings showed that patients of all ages, with a variety of diseases, could profit from rehabilitation services. Implications of the study for the improvement of the treatment process are discussed. Dr. Harry L. Leonard and Mrs. Anne S. Weitz of the Psychology Department, Hillyer College, University of Hartford, were associate directors of the Project. Dr. Edward Scull is medical consultant to the Center, which is under the direction of Miss June Sokolov. 63 references.

SHELTERED WORKSHOPS

378. **National Rehabilitation Association** *(1025 Vermont Ave., Washington 5, D.C.)*

Sheltered workshops; NRA policy. *J. Rehab.* Jan.-Feb., 1960. 26:1:19-20.

A statement formulated in 1959 by the Association's Rehabilitation Policy Committee and adopted by the Board of Directors in October. Included is a definition of what constitutes a sheltered workshop and its functions, with a concise discussion of the essential characteristics and responsibilities of, and the need for, sheltered workshops. It is the Association's belief that the federal government should assume specific responsibilities and provide certain services to workshops. The Association's role in the promotion of such services to the handicapped is stated.

SHELTERED WORKSHOPS—GREAT BRITAIN

379. **Rehabilitation.** Jan.-Mar., 1960. No. 32.

Partial contents: An employer's view of the disabled, Gerald F. Keatinge, p. 7-10.—Training opportunities for the disabled who cannot return to their former work, W. A. Deacon, p. 11-12.—LuDun Limited; the first ten years, T. L. Lightfoot, p. 13-17.—Rehabilitation and sheltered employment in Holland, John Arthur, p. 18-20, 27.—Papworth and Enham-Alamein Village Settlement, R. R. Trail, p. 21-27.

Dr. Keatinge discusses employment of the disabled in competitive industry. Mr. Deacon, of the Portland Training College for the Disabled, Mansfield, considers employment possibilities for disabled persons unable to return to their former jobs following rehabilitation, as well as the social and vocational barriers to employment. Mr. Lightfoot and Mr. Trail describe experiences of three sheltered workshops in England. Mr. Arthur's article is a continuation of a conference report begun in the Oct.-Dec., 1959 issue of *Rehabilitation* (see *Rehab. Lit.*, Jan., 1960, #63).

SPECIAL EDUCATION—ADMINISTRATION

380. **Wallace, Helen M.** *(U.S. Children's Bureau, Washington 25, D.C.)*

School services for handicapped children in urban areas, by Helen M. Wallace and Helen M. Starr. *Am. J. Public Health.* Feb., 1960. 50:2:173-180.

Another in the series of analyses of school services for handicapped children, derived from data submitted in answer to a questionnaire sent to 106 cities with a population of 100,000 or more. (For others in the series, see *Rehab. Lit.*, Mar., 1960, #210, and Apr., 1960, #264.) Wide variation in the range of services and the types of handicapped children served was revealed; suggestions for improving and strengthening services are offered.

SPECIAL EDUCATION—BIBLIOGRAPHY

381. Kvaraceus, William C. *(332 Bay State Rd., Boston, Mass.)*

Selected references from the literature on exceptional children. *Elementary School J.* Mar., 1960. 60:6:343-348.

The 64 references listed were published between January and November, 1959, and concern educational technics for work with the gifted, juvenile delinquents, emotionally disturbed and dependent, and the mentally or physically handicapped. Similar bibliographies are published annually in the *Journal.*

SPECIAL EDUCATION—PROGRAMS

See 320.

SPEECH CORRECTION

382. Wood, Nancy E. *(11206 Euclid Ave., Cleveland 6, Ohio)*

Clinical problems in speech and language. *Arch. Phys. Med. and Rehab.* Mar., 1960. 41:3:103-110.

In same issue: Psychological aspects of the development of speech and language, Ernest Henrikson, p. 95-102.

Clinical problems in relation to the diagnosis and therapeutic treatment of aphasia, alexia, and agraphia caused by cerebral vascular accidents, brain tumors, or head injuries and of congenital aphasia caused by anoxia, febrile episodes, or birth injury are presented. Dr. Wood emphasizes the need to integrate speech and language therapy with total rehabilitation plans for the patient. Speech problems cannot be considered as peripheral.

Dr. Henrikson *(Univ. of Minnesota, Minneapolis 14, Minn.)* points out the complex interaction between the individual and his environment in the development of communication skills. Psychological factors to a large extent can determine the influence that physical variations have on the development of speech and language. The implication of these considerations to future research in the field of speech is discussed. Both papers were presented at a seminar on "Rehabilitation in Speech and Language," held at the 1959 annual meeting of the American Academy of Physical Medicine and Rehabilitation.

SPEECH CORRECTION—ADMINISTRATION

383. Lillywhite, Herold S. *(3181 S.W. Sam Jackson Park Rd., Portland 1, Ore.)*

Some problems of relationships between speech and hearing specialists and those in the medical profession, by Herold S. Lillywhite and Richard L. Sleeter. *Asha,* Am. Speech and Hear. Assn. Dec., 1959. 1:4:127-131.

In same issue: The need for adequately trained speech pathologists and audiologists, ASHA Committee on Legislation, p. 138-139.

The authors suggest some solutions for the betterment of professional relations and for the establishment of more effective communication between physicians and specialists in speech and audiology.

On p. 138 is a statement prepared by the Liaison Sub-committee of the American Speech and Hearing Association's Committee on Legislation, to aid Association members called upon to testify at hearings held by U.S. Senate and House committees interested in special education and rehabilitation legislation. Data are included on the estimated incidence and prevalence of speech and hearing problems in school-age children and in the population as a whole. Estimates of need for trained personnel and the educational and financial resources needed to train such persons are given.

SPEECH CORRECTION—INSTITUTIONS—DESIGNS AND PLANS

384. Frisina, D. Robert *(Gallaudet College, Washington 2, D.C.)*

Gallaudet's new hearing and speech center. *Asha.* Mar., 1960. 2:3:68-69.

Floor plans and construction details of a small hearing and speech center of circular design, recently built at Gallaudet College, are described and illustrated. The shape of the building allows an easy flow of traffic (individual rooms are located in functional units) and permits easier handling of the more than 400 persons per week receiving services of the Center.

SPLINTS

385. Swanson, J. Norrie *(200 St. Clair Ave. W., Toronto 7, Ont., Canada)*

Dura-foam splints in general and specialist practice, by J. Norrie Swanson and H. F. Pierce. *Applied Therapeutics.* Jan., 1960. (10) p.

Describes a new plastic material for making splints that has been undergoing clinical trial for the past two years. New technics for its use in splinting the extremities and trunk in both surgical and medical conditions are discussed and illustrated. An evaluation of the advantages and disadvantages of Dura-foam over older methods has been made on the basis of three years' experience with the product.

VOCATIONAL GUIDANCE

386. Moed, Martin G. *(400 First Ave., New York 10, N.Y.)*

Personal and social factors influencing employment of the cerebral palsied. *Personnel and Guidance J.* Mar., 1960. 38:7:567-570.

Findings from studies made in conjunction with the Cerebral Palsy Evaluation Project of the Institute for the Crippled and Disabled, New York City, showed that ability to travel independently, to write legibly and to speak intelligibly, manual dexterity, and behavior termed vocational adjustment are factors related to ability to find employment. Prevocational evaluation, the provision of sheltered workshops, and vocational training are services that could overcome many of the problems of the cerebral palsied young adult seeking employment. (See *Rehab. Lit.,* April, 1960, # 298.)

See also 314.

Events and Comments

(Continued from page 161)

Yeshiva Education Featuring Articles on Exceptional Children

WITH THE FALL 1959 issue *Yeshiva Education* began a series of articles on exceptional children in the day school. "The Mentally Defective Child," by Boris M. Levinson will be followed by articles on children who are intellectually gifted, delicate, crippled, blind, hard of hearing, and emotionally disturbed. *Yeshiva Education*, a semiannual publication, is published by the National Council for Torah Education of Mizrachi-Hapoel Hamizrachi, 80 Fifth Ave., New York, N.Y. (subscription rate, 50¢ a copy, $1.00 a year).

A Blind Child Is Not a Statistic

IN THEIR PIONEER study *Services to Blind Children in New York State*, Drs. Cruickshank and Trippe documented the status of the blind child in the state and offered recommendations for their education and welfare. (See book review in *Rehab. Lit.*, Aug., 1959, p. 234.) To focus greater attention on the report, the American Foundation for the Blind (15 W. 16th St., New York 11, N.Y.) has issued the booklet *A Blind Child Is Not a Statistic*, by Lucy Freeman and Kathern F. Gruber. Citizens of the state—and of other states—will find it a useful guide to action.

Indiana Appoints Henley Field Representative of Division of Rehabilitation

THE INDIANA General Assembly in 1959 established a Commission for the Handicapped, with the Division of Rehabilitation as its administrative arm. Charles E. Henley has been appointed field representative for the Division; the director is yet to be named. Mr. Henley was formerly director of the Division of Special Education of the State Department of Public Instruction.

National Health Council Names President and President Elect

DR. JAMES E. PERKINS of New York, managing director of the National Tuberculosis Association since 1948, became president of the National Health Council on March 17 at the annual meeting in Miami Beach following the conclusion of the 1960 National Health Forum. Dr. James H. Sterner, medical director of Eastman Kodak Company, Rochester, N.Y., was named president-elect and will succeed Dr. Perkins in 1961. The Council, founded in 1920, has as members 71 national voluntary health agencies, professional societies, and public service organizations.

Rehabilitation Needs of Kansas City Area Reported

THOSE following activities of Community Studies, Inc., (724 Railway Exchange Bldg., Kansas City 6, Mo.) in their survey of rehabilitation services for the Kansas City area, will be interested to note several reports recently issued. The *Metropolitan Area Health Survey*, by Warren A. Peterson *(Pubn. 127, June, 1959, 319 p., mimeo.)*, reports the prevalence of types of disability and chronic disease. The "rehabilitation needs" of persons surveyed will be given more concise interpretation in a later report. The present report is one of several from the Greater Kansas City Rehabilitation Survey and Demonstration, a project supported in part by research grants from the National Institutes of Health and Office of Vocational Rehabilitation. *Missouri Nursing Homes (Pubn. 128, Aug., 1959, 87 p., mimeo.)* and *Kansas Nursing Homes (Pubn. 129, Nov. 1959, 105 p., mimeo.)* both by Eleanor Poland, Dr. Paul A. Lembke, and Max Shain, provide data on nursing homes, boarding homes, homes for the aged—and their patients or residents—in the two states. These two reports are for the Regional Health and Hospital Study supported in part by a research grant from the Division of Hospital and Medical Facilities, Bureau of Medical Services, of the U.S. Public Health Service. Dr. W. D. Bryant is executive director of Community Studies, Inc., of Kansas City.

Nutritionists and Home Economists to Discuss Rehabilitation

THE THEME of a workshop scheduled for June 25 to 27 by the American Home Economics Association and the American Dietetic Association Joint Committee on Rehabilitation will be "Expanding Services of the Home Economist in Rehabilitation." All interested persons are invited to attend the workshop, which is to be held in Denver, prior to the A.H.E.A. meeting. Foods and nutrition, homemaker service, and "meals-on-wheels" will be featured.

National Epilepsy League Publishes Bibliography

NOW AVAILABLE from the National Epilepsy League (208 N. Wells St., Chicago 6, Ill.) is *Epilepsy Bibliography, January, 1956, to January, 1960*. This 23-page mimeographed review of the literature, compiled by Dr. George Nelson Wright, the League's program director, indexes and annotates periodical articles, pamphlets, and books selected for their usefulness to the student or professional worker in the field of epilepsy. Medical abstracts are included when of interdisciplinary scope.

Report Published on Institute For Rehabilitation Executives

A TRAINING institute for Easter Seal executives in Pennsylvania was conducted in November, 1959, by the Pennsylvania Society for Crippled Children and Adults (1107 N. Front St., Harrisburg). *A Tree Grew in Bedford*, the report on the planning, conduct, and results of the institute, has just been published by the state society. The U.S. Office of Vocational Rehabilitation supported the institute by a grant. As a pilot project, the institute was regarded as a means not only to improve the services of local voluntary rehabilitation agencies in Pennsylvania but also to set a pattern for inservice training programs for administrators in other states.

Boston College Schedules New Personnel Course in Rehabilitation of Blind

THE WORLD'S FIRST training program for *mobility instructors*, a new designation for rehabilitation personnel concerned with the restoration of effective physical mobility, confidence, and safety of travel in blind persons, will begin June 27 at Boston (Mass.) College School of Education. Practical training at St. Paul's Rehabilitation Center for the Blind will augment the academic and theoretical studies. The 14-month course, given under a grant from the Office of Vocational Rehabilitation, will be open to eight trainees.

Cleveland Hearing and Speech Center Reports Activities

ACCORDING TO the 1959 Annual Report, the Cleveland Hearing and Speech Center (11206 Euclid, Cleveland 6, Ohio) provided individual service to 2,364 persons with speech (1,240), hearing (1,085), or reading (39) problems. The total number using the service was 3,009, with the addition of 645 Western Reserve University freshmen screened for speech and hearing. Over 31,000 half-hour periods of therapy were given.

The 1,240 persons with speech or language disorders (41.3% of the total seen) fell into the following groups:

	No.	*Percent*
Articulation	561	18.6
Delayed Speech	310	10.3
Stuttering	193	6.4
Adult Aphasia	39	1.3
Voice	75	2.6
Post-Laryngectomy	33	1.1
Cleft Palate & Lip	13	.4
Foreign Accent	14	.5
Cerebral Palsy	2	.07

Author Index